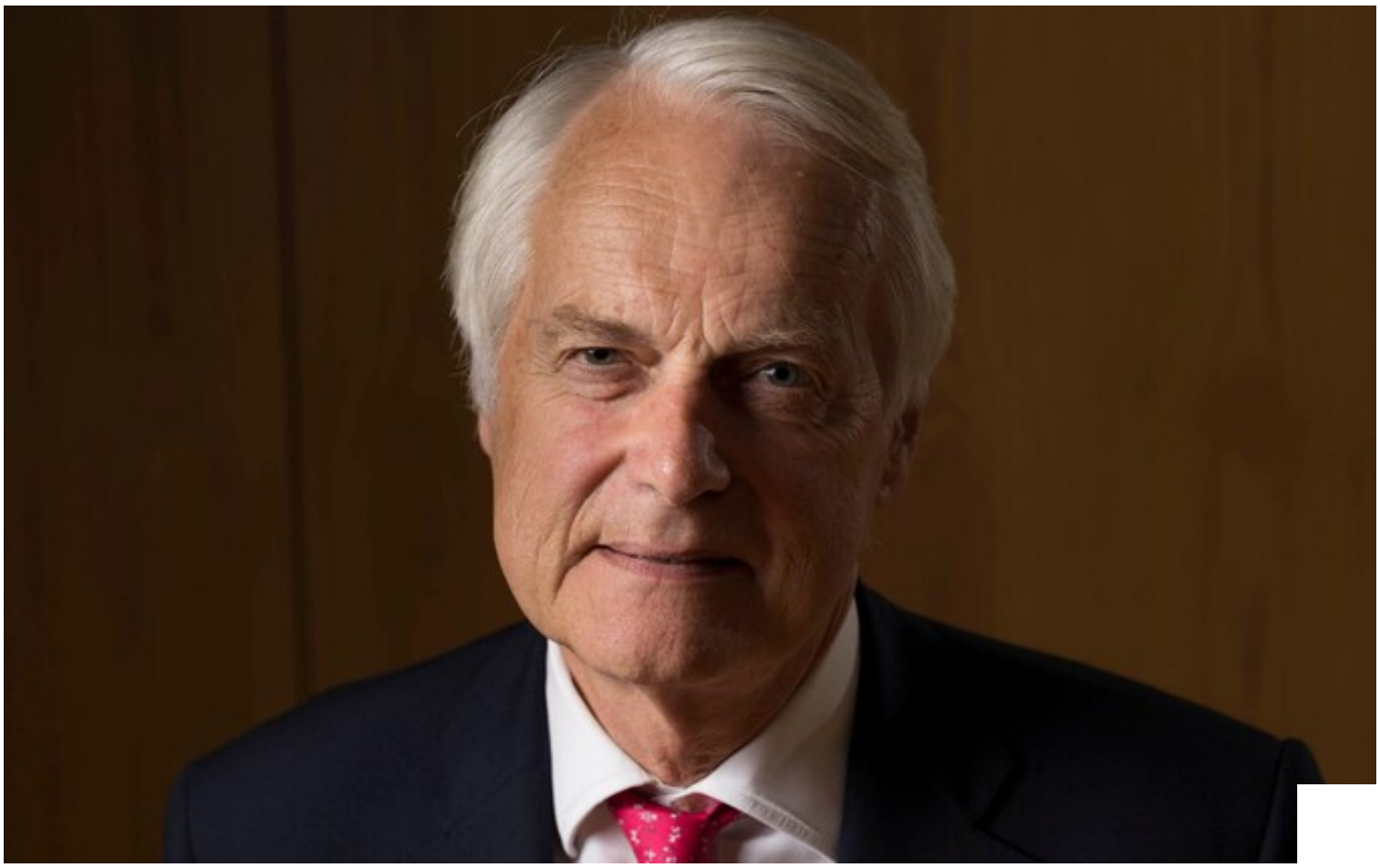

Sir Robert Francis: 'This is not just about Lucy Letby – the NHS system doesn't value safety'

The Patients Association president, who also chaired the inquiry into Mid Staffs, fears patients are being put at risk by bad management

By Eleanor Mills

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Sir Robert Francis is the kind of patrician grey-haired chap who gives the establishment a good name.

A barrister, King's Counsel, and president of the Patients Association, he's the man we trust to chair big inquiries when things go terribly wrong in the NHS.

The lessons for the NHS that came out of his epic five-year inquiry into high numbers of deaths in elderly patients at Stafford hospital enshrined a "duty of candour" in the NHS. His lessons on accountability and culture are taught to all medical students.

If ever there was a moment for his cool, experienced head, this is it. This week saw the conviction of Britain's most prolific female serial killer; a nurse whose victims were the most vulnerable patients of all – premature and critically-ill babies.

The perpetrator of these unimaginably awful crimes was Lucy Letby, 33, a nurse at the Countess of Chester Hospital, who worked in the neonatal unit and in neonatal intensive care. After a nine-month trial and six weeks of jury deliberation, she has been found guilty of murdering seven babies and attempting to murder another six.

In his closing speech, the prosecuting barrister said, "Letby revelled in what she had done and enjoyed the anguish and distress she had caused".

Letby worked at the neonatal unit at the Countess of Chester Hospital | CREDIT: Christopher Furlong/Getty Images

It is expected that Letby will serve a whole-life sentence in prison – not that that will bring back the children who lost their lives, or comfort their grieving parents. And this may not be the full extent of her crimes.

Cheshire police are already pursuing a number of active investigations, including examining 4,000 admissions of babies to neonatal units at the Countess of Chester and Liverpool Women's Hospital, where Letby worked between 2012 and 2016.

Consultants on the Countess of Chester unit raised concerns about the unusually high rate of baby deaths, but the hospital was slow to act on their concerns. When "lovely Lucy", as her fellow medics called her, was finally suspended from duty, hospital administrators kept trying to force doctors to reinstate her on the ward, citing "staff shortages".

A BBC investigation found that hospital bosses failed to investigate allegations against Letby and tried to silence doctors. The unit's lead consultant Dr Stephen Brearey raised his worries about Letby in October 2015, but no action was taken. It was three years until Letby was arrested –and it took Brearey going to the police, as a last resort.

Sir Robert, aged 73, has spent his entire career trying to ensure patient safety. How does he think we can stop something like this case happening again? "The first thing to say is to recognise the suffering of the families involved in this shocking tragedy and how awful the staff at the hospital will be feeling, too," he says, twinkly and dapper in a sharp navy-blue suit and shocking-pink tie when we meet at his chambers Serjeants' Inn in Fleet Street.

"There needs to be a proper, independent and transparent review of everything that happened as swiftly as possible, but I would say not another public inquiry. We don't need five years of looking at this to come to the same conclusions about putting patient safety at the forefront."

He talks about recommendations after previous inquiries for the establishment of

independent medical examiners, whose job is to investigate unexplained deaths in hospitals and work with the coroner. "We need to find explanations for startling facts [like extra babies dying]. To do that, we need people who are skilled at investigations and who are independent doctors."

Unfortunately, these are still not in place in the NHS, partly because of costs. Sir Robert intimates that such an external eye could have prevented more deaths in the Letby case.

One of the reasons it has taken so long to get verdicts is because it was such a difficult case to prosecute. Letby was cunning at covering her tracks.

"It was almost entirely circumstantial evidence, hardly any forensic evidence, lots of clinical evidence relying on recollection which has contributed to the length of the trial," he explains. "There are some learnings about behaviours, particularly about Letby's weird approaches to parents and families after the deaths. But it's difficult to lay down rules and policies because you can't make rules about personalities.

"Dr Harold Shipman, the most prolific NHS serial killer, was thought to be a nice, kindly chap, popular with his patients," he continues. "Some of the most notoriously horrible people can be brilliant surgeons. We need to look at the objective facts and it seems like the consultants who were worried and correlated the deaths with the presence of Letby were looking at objective facts."

The explanations are not always sinister, he points out. "Florence Nightingale looked at why people were dying in one ward and not another – turned out it was because people weren't washing their hands. But we do need to look at the facts and if there are more deaths than usual that needs to be made a priority."

This is at the core of Sir Robert's work. "At the heart of this tragic case are concerns raised by doctors about the safety of patients who have died. Whenever that happens, the prime concern in any investigation is to start with the safety of the patient, because if you have concerns about patients then you act urgently. If you start looking at disputes between individuals, or HR procedures, then you get into trouble, things lag."

These insights are hard-won; not just from his decades as a leading medical negligence barrister, but from his epoch-defining inquiry and report into the failures of Mid Staffordshire NHS Foundation Trust in 2014. It is now a compulsory text in all doctor's training and outlined in detail how up to 1,200 patients died, who shouldn't have, because between 2005 and 2008, hospital bosses prioritised "making cutbacks to staffing in services in order to make millions of pounds worth of surpluses".

Cure the NHS campaigners arrive at the Stafford Civic Centre for the public inquiry into Stafford Hospital in 2010 | CREDIT: Christopher Furlong/Getty

He made such a name for himself as a champion of patients' safety with the report, that

afterwards he became president of the Patients Association, chair of Healthwatch England and also chaired an NHS review into protecting whistleblowers called the Freedom to Speak Up review. His career has been spent digging deep into how regulators, government, politicians, and administrators in the NHS can fuel care disasters and exposing how a culture from the home secretary downwards can become remote from the reality of service at the front line.

There are obvious parallels between the reluctance of managers to act in the Letby case and the Mid Staffs scandal. Sir Robert points out that in the Mid Staffs inquiry, rather than focusing on risks to patients, when it was found that the hospital's death rates were significantly higher than they should be, managers "attacked the statistical basis of the data rather than starting with patient safety".

In the Letby trial much was made by the hospital of "staff shortages" as a reason for why Letby needed to be reinstated on the ward (she also brought a grievance procedure against the hospital).

Sir Robert sighs. It must be depressing to be like Cassandra, warning of the risks and seeing the same issues recur. "It comes back to the pressures within the NHS system, if you are under pressure from the demands of lots of patients," he says. "Nothing is more testing than looking after intensive care patients when you haven't the staff to do the job. Basically, if there aren't enough staff to run a unit safely, then it should be shut down and patients moved to other hospitals."

The Letby trial heard how senior consultants repeatedly raised safety concerns about Letby with hospital management, but that they kept insisting she should be reinstated – the implication being because of staff shortages on the wards (this was found to be the case in a Care Quality Commission report into the unit at the time).

If the doctors' warning had been heeded and the hospital had acted sooner, she might have been stopped earlier and lives saved. Sir Robert shakes his head. The twinkle is in abeyance for now. "I'm afraid in the NHS people are influenced by the systemic pressures put on them to take decisions that in the ideal world they wouldn't take."

This is the crux of the matter. "It's a question of priorities," he says. "In the NHS now there are lots of pressing priorities. The big one is waiting lists which are terrible… It's a problem of excessive demand over supply and that will" – he immediately corrects

himself to a more diplomatic "could lead to dire social consequences, which might include the collapse of the service or that the service becomes so ineffective that people look at different ways of doing it."

That's quite the warning. Sir Robert delivers it in such a measured way that the full impact of what he has said doesn't hit me until I relisten to my tape.

He is adamant that despite the current strikes about pay, the NHS's problems are not just financial. "What I hear is people within the NHS feeling increasingly undervalued. It is not just a question of money."

When I suggest that the 30 per cent pay increase that the doctors are demanding sounds unrealistic, he laughs, and replies: "well, it's a negotiation, when I go to a judge with a big figure for a medical negligence claim it's an opening position". He certainly seems to think there is scope for dialogue.

"What the Government needs to understand is that this is a question of the working conditions," he says. "When I talk to doctors they say pay matters, but there is just as much that needs to be looked at in terms of working conditions; rostering, burnout, trauma.

If that was tackled effectively they would be less strident about pay. It's as basic as doctors working all night but not being able to get anything to eat because the canteens are closed. Or them not being able to get a drink of water, or have a lie-down because those facilities have been withdrawn. Fundamentally, many of the problems in the NHS are down to bad management. I don't think there is anywhere in the private sector that would behave this badly. It's an accident waiting to happen."

‘When things go majorly wrong it is not only about rogue individuals like Letby or Shipman, but a system which doesn’t value safety and prioritise patients’ | CREDIT: Andrew Crowley

He goes on to explain that from his many years of investigating medical negligence it is always when the system gets put under this kind of pressure, that things go wrong. “I am concerned about patient safety because when things get this bad there is a lack of speaking up; pressure on staff just to do the work, even when that becomes impossible, when junior doctors are so tired they can’t drive home…All NHS staff feel a moral imperative to look after patients, but they can’t when just doing their jobs is such a threat to their wellbeing.

“It’s not about snowflakes, or not being resilient. Anyone who has done five years of basic training as a doctor is resilient. It becomes worrying to me when it becomes normal just to put up with it. You don’t want to let your colleagues down so you keep going – and then junior doctors have concerns about patient safety or around practices of senior colleagues and don’t speak up. That’s dangerous and puts patients at an unacceptable risk.”

Sir Robert points to an 11.3 per cent increase in serious patient safety incidents in the past six months. That’s 2,435,800 incidents – “and each of those two-and-a-half million is a person: your mum, your wife, your baby, your father. Those are just the ones that are reported”.

Yet despite Letby and the increase in unsafe incidents, Sir Robert sounds a comforting note by saying that things are way better than they used to be. “When I started working in medical negligence as a young lawyer in the 1970s such claims hardly existed because no doctor would give evidence against another.

“I’ve seen a massive shift in terms of claims and taking responsibility. We hear about

what has gone wrong more. The duty of candour [this enshrines the notion that doctors and nurses must tell the truth about what has happened to preserve patient safety] that I talked about in the Mid Staffs report is there. I do hear that NHS workers now feel a protection in terms of speaking up when things go wrong."

We saw this in the Letby case, when the neonatal consultants did raise the alarm.

So what needs to be done? "There is a retention crisis. A General Medical Council survey showed that 40 per cent of NHS workers are thinking of leaving, 60 per cent say they can't cope and it's getting worse all the time," he says. "Staff feel undervalued. Not listened to. They are stressed, burnt-out, doing unpaid work, beyond the hours they are contracted for.

"Why wouldn't a nurse want to move to Australia? Putting more money into the system without plugging some of these basics, and sorting out the management, is like putting water in the bath without putting the plug in."

But Sir Robert warns against more NHS reorganisations and targets. "It was a big reorganisation that led to Mid Staffs and the negative culture. I will never forget a woman in that inquiry telling me how she arrived to find her elderly mother naked, barely covered with a sheet, in full view of the corridor, and with faeces dried on to her sheets, which were also soaked in urine. The worst thing about that was that she'd been like that for a long time – many people had seen it and done nothing. That is when an institutional culture becomes dangerous."

I ask what other cases haunt him. "I'll never forget the story of a woman with a broken hip who came to A&E, she was diabetic and it said clearly on her notes: needs insulin. But 11 days later she had been given no insulin and she died. In the hospital. It's the thoughtlessness behind lots of these unsafe practices which leads to harm and death. When things go majorly wrong it is not only about rogue individuals like Letby or Shipman, but a system which doesn't value safety and prioritise patients. It's when people aren't listened to, that's when bad things happen."

Does he feel optimistic about the future of the NHS, or is it broken beyond repair? "No," he replies to the latter, with passion. I believe him. As long as the NHS has wise critical friends such as Sir Robert, it stands a chance of staying the distance.

NB *Since the publication of this article, Sir Robert has modified his view on the statutory/non-statutory inquiry issue. His position is now as reported in The Times today (22.08.2023).*

Francis — who led inquiries into the appalling suffering endured by hundreds of patients as managers obsessed with targets ignored staff concerns — said: *"My initial thoughts were in favour of a non-statutory inquiry simply because you could get on with it, the lessons to be learned could be found more quickly. The disadvantage is you can't compel people to give evidence, it's not given on oath and so on".*

He said the government should *"appoint a chair of the inquiry in a non-statutory way but task that chair with consulting those concerned, particularly bereaved families, about terms of reference and whether it should be statutory or non-statutory."*

Francis said: *"I had in Mid Staffs the experience of both [statutory and non-statutory] and I thought that worked quite well, starting with the non-statutory which allowed me much more flexibility in how I could go about investigating, talking to people, learning how things happened, and then having a statutory inquiry looking at the wider system picture".*

He suggested the need for a police investigation into other cases would delay some elements of the inquiry, meaning these could potentially be the subject of a wider statutory probe later.

"What happened in [the] hospital, what concerns were raised and how they were dealt with could be the start whereas the wider picture could follow," he said. *"There is time to do a consultation and perhaps work out a structure of what can be done sooner and what would wait until more is known".*

Witherow, T. 2023. Lucy Letby whistleblower: regulate NHS managers like doctors. *The Times* [Online] August 22 2023 Available from: https://www.thetimes.co.uk/article/lucy-letby-whistleblower-regulate-nhs-managers-like-doctors-92h9gr2d9