
Francis Report

Report into Mid Staffs

The full report is available on <http://www.midstaffsinquiry.com/documents.html>

What happened?

Patients were failed by the system and a culture in which Trust Board did not listen to staff and patient concerns. They ignored warning signs that there were problems - and money, rather than quality was the priority.

In 3 years 400-1200 patients died in excess of the number expected...wards were dirty, patients were left unwashed, without food, medicines weren't given, care was delivered without dignity and staffing levels were poor

- The patient voice was not heard by the Trust Board or local organisations.
- Complaints were made but often nothing effective was done about them.
- High mortality rates were not investigated
- Medical staff did not raise concerns until it was too late.
- Trust issued statements about safety and quality that were reassuring - but these were not challenged

Call to action...What needs to change at the clinical level? ...

PUT THE PERSON IN THE PATIENT...

- patients interests and safety have to come first
- each patient will have a 'named clinician'
- staff and patients should feel confident raising concerns
- questions answered fully and truthfully
- duty to tell the truth to patients - where there is poor care or an error the patient is told - even if they haven't made a complaint or asked questions

***Do you always
put the person in the patient?***

At a Glance...