7.3: The Francis Report

A public inquiry into poor care at the Mid Staffordshire NHS Foundation Trust in the UK documented the unnecessary deaths of up to 1,200 people between 2005 and 2009 (Francis, 2013). The first report (Francis, 2010) coming out of the inquiry described an organization that was focused on saving money and creating efficiencies in the system rather than on providing safe quality care to patients. The second report (Francis, 2013) advocated for the organizational culture to be changed to a culture where patient safety and well-being would be the primary focus of management and staff (Muls et al., 2015). Shock waves swelled throughout the UK as news regarding the abusive care spread to the public. Major regulatory organizations and all trusts in the UK reviewed their policies, procedures, and actual processes for provision of care. Action plans were developed to create change and ensure that organizations had a culture responsive to patients’ needs and preferences, with an emphasis on patient safety.

Essential Learning Activity 7.2.1

Watch this video of Catherine Foot interviewing Robert Francis QC (chair of the Francis inquiry) titled “Catherine Foot in conversation with Robert Francis” (9:47), then answer the following questions:

1. Describe one of the patient stories that Francis shared. Why did the board or coroner not hear about this patient?
2. Why did staff not come forward with examples of poor patient care?

Watch a short video titled “Diane Eltringham: Nurses responses to the Francis Report” (3:04), then answer the following questions:

1. What happened to care delivery after the Francis report?
2. How has the organizational culture changed?
3. What was the change that made the biggest difference to patient care?