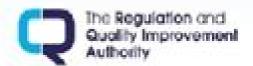
Mid Staffordshire NHS Foundation Trust

The Francis Report





Mid Staffordshire Nhs Trust Report

Sarah Harvey

Mid Staffordshire Nhs Trust Report:

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Mid Staffordshire NHS Foundation Trust Public Inquiry, Robert Francis, 2013-02-06 This public inquiry report into serious failings in healthcare that took place at the Mid Staffordshire NHS Foundation Trust builds on the first independent report published in February 2010 ISBN 9780102964394 It further examines the suffering of patients caused by failures by the Trust there was a failure to listen to its patients and staff or ensure correction of deficiencies There was also a failure to tackle the insidious negative culture involving poor standards and a disengagement from managerial and leadership responsibilities. These failures are in part a consequence of allowing a focus on reaching national access targets achieving financial balance and seeking foundation trust status at the cost of delivering acceptable care standards Further the checks and balances that operate within the NHS system should have prevented the serious systemic failure that developed at Mid Staffs The system failed in its primary duty to protect patients and maintain confidence in the healthcare system This report identifies numerous warning signs that could and should have alerted the system to problems developing at the Trust It also sets out 290 recommendations grouped around i putting the patient first ii developing a set of fundamental standards easily understood and accepted by patients iii providing professionally endorsed and evidence based means of compliance of standards that are understood and adopted by staff iv ensuring openness transparency and candour throughout system v policing of these standards by the healthcare regulator vi making all those who provide care for patients properly accountable vii enhancing recruitment education training and support of all key contributors to the provision of healthcare viii developing and sharing ever improving means of measuring and understanding the performance of individual professionals teams units and provider organisations for the patients the public and other stakeholders Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Mid Staffordshire NHS Foundation Trust, 2013 Patients First and Foremost Great Britain: Department of Health, 2013-03-26 This is a Government response to HCP 898 ISBN 9780102981469 the inquiry into the Mid Staffordshire NHS Foundation Trust on the failure of care It sets out a collective commitment and a plan of action to eradicate harm and aspire to excellence and to ensure that patients are the first and foremost consideration of the system and everyone who works in it and so restore the NHS to its core humanitarian values This response sets out a five point plan under the following headings A Preventing problems B Detecting problems quickly C Taking action promptly D Ensuring robust accountablity E Ensuring staff are trained and motivated Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Robert Anthony Francis, 2013 Cast Study Critique Report on "Francis Report 2013 (Recommendation 15)" About Mortality Statistics Kamalesh Dey, 2016-07-27 Seminar paper from the year 2016 in the subject Health Public Health University of Bedfordshire MBA Health Services Management course Organising Modern Health Care Services language English abstract The report explored the Francis report regarding Mid Staffordshire NHS Foundation The report also examined and analysed the

recommendation 15 of Francis report based on Mid Staffordshire NHS Foundation The report mainly highlighted the mortality statistics of the Mid Staffordshire NHS Foundation and how mortality statistics influenced the entire hospital as well as NHS foundation trust through the different performance strategies Mortality statistics was done through data collection data analysis assessing hospital performance and publishing the final audit report while the report highlighted that auditing was the best strategy to improve the total performance of the hospital In addition the critique report recommended seven principles for medical auditing for instances clinical and health providers individual s duty self management of the medical staffs availabilities of the auditing essential criteria of the auditing required resources of the medical auditing record keeping and evaluation of the final audit outcomes by various medical and non medical experts These seven principles were identified as effective and significant to provide the quality care of the patients and improve the overall performances of the medical organisations Operations of Regulators of Healthcare Professionals, Volume 4 Marc Seale, 2025-10-28 A comprehensive and authoritative reference on the principles and processes for regulating healthcare professionals In Operations of Regulators of Healthcare Professionals renowned international regulator Marc Seale delivers an authoritative discussion on the operations of healthcare regulators addressing the administration and management of regulators communication governance and standards for regulators This comprehensive reference work examines all components of the regulators of healthcare professionals providing clear definitions and analysis lacking in the existing literature on the subject and offers a practical guide for understanding a complex regulatory landscape Readers will also find A thorough introduction to the administration and management of regulators communication and governance Comprehensive explorations of the service standards operational performance of regulators and regulatory failure Practical discussions of planning and research the history and reform of regulating healthcare professionals and standards for regulators A review of the future of the regulation of healthcare professionals Perfect for the educators and teachers of healthcare students Operations of Regulators of Healthcare Professionals will also benefit healthcare students consumer advocacy organisations healthcare employers professional associations lawmakers and regulators **Strategies for Compliance** Alan Brener, 2020-12-20 Compliance is a fundamental control function within regulated industries globally This book provides an expert introduction to corporate compliance using cases examples and insights from the financial services sector and beyond The author an experienced compliance practitioner and academic highlights compliance challenges using examples such as Wells Fargo whistleblowing in the financial services and the mis selling of payment protection insurance in the UK banking sector The book explores strategies for creating compliant cultures and fostering regulatory trust whilst practical guidance is provided on anticipating regulatory changes Addressing organisational obstruction and delay the author presents a series of valuable tools and techniques for real world practice An essential professional development resource for board directors compliance officers and other senior managers the book also provides a unique learning and development resource for students of

corporate compliance globally **Research Handbook on Leadership in Healthcare** Naomi Chambers,2023-09-06 This timely Research Handbook provides a comprehensive and transdisciplinary overview of current research in the field of health leadership Emphasising diverse perspectives and under explored issues it calls for a sustainable future embracing social justice technological innovation and artificial intelligence patient centredness of care and the fair treatment of workers This title contains one or more Open Access chapters House of Commons: Sessional Returns - HC 1 Great Britain: Parliament: House of Commons, 2013-09-13 On cover and title page House committees of the whole House general committees and select committees On title page Returns to orders of the House of Commons dated 14 May 2013 the Chairman of Ways and Means

Change Management for Quality Improvement. A Case Study of the Mid Staffordshire Hospital Scandal
Leonard Kahungu,2018-07-09 Case Study from the year 2018 in the subject Health Public Health grade 70 00 language
English abstract Guaranteeing that the National Health Service Organisations and the affiliated human resources deliver
high quality and equitable care is one of the major priorities in the contemporary health services Yet the metrics necessary to
evaluate the quality and assurance of the healthcare is a matter subject to continuous debate In the recent past the concerns
associated with the quality of care has attracted wide ranging interests particularly by the Mid Staffordshire Hospital scandal
An inquiry report into the Mid Staffordshire NHS Foundation Trust the Francis Report released on February 2013 paints a
grim picture of the events that transpired during fermentation of the scandal Unfortunately these events led to the loss of
lives due to issues which could have been managed or addressed better Briefly the Stafford and Cannock Chase hospitals
decided to pursue the Foundation Trust in 2005 which was subsequently granted in 2008 However abnormally high death
rates raised eyebrows from various quarters triggering the formulation of the taskforce to look into the matter It is largely
believed that the scandal was triggered by the quest of the managers to cut down the operational costs and accomplish the
minimum labour requirements in attempts to achieve the foundation status and qualify for the NHS trust funds This indicates
that the scandal was a result of catastrophic organisational challenges that were triggered by poor change management

How Did Britain Come to This? Gwyn Bevan,2023-10-23 If every system is perfectly designed to get the results it gets what is wrong with the design of the systems that govern Britain And how have they resulted in failures in housing privatisation outsourcing education and healthcare In How Did Britain Come to This Gwyn Bevan examines a century of varieties of systemic failures in the British state The book begins and ends by showing how systems of governance explain scandals in NHS hospitals and the failures and successes of the UK and Germany in responding to Covid 19 before and after vaccines became available The book compares geographical fault lines and inequalities in Britain with those that have developed in other European countries and argues that the causes of Britain's entrenched inequalities are consequences of shifts in systems of governance over the past century Clement Attlee's postwar government aimed to remedy the failings of the prewar minimal state while Margaret Thatcher's governments in the 1980s in turn sought to remedy the failings of Attlee

s planned state by developing the marketised state which morphed into the financialised state we see today This analysis highlights the urgent need for a new political settlement of an enabling state that tackles current systemic weaknesses from market failures and over centralisation This book offers an accessible analytic account of government failures of the past century and is essential reading for anyone who wants to make an informed contribution to what an innovative capable state might look like in a post pandemic world Medical Accident Liability and Redress in English and French Law Simon Taylor, 2015-06-11 In 2002 France introduced an out of court settlement scheme for medical accidents The scheme quarantees compensation for the victims of the most serious medical accidents irrespective of fault and operates in parallel with existing liability rules In this book Simon Taylor compares English and French law on medical accident liability and redress and considers what lessons the French model can provide for potential reform in England and elsewhere Taylor emphasizes the effect of the English and French rules on access to compensation and on the cost of liability and examines the problems that have been posed by the introduction of an administrative redress scheme in France This book looks at the potential consequences of English and French rules for the doctor patient relationship and for patient safety and considers the role that national legal traditions and cultures of civil liability in England and France play in shaping national law in this Healthcare, Quality Concerns and Competition Law Theodosia Stavroulaki, 2023-01-26 Market driven healthcare is massively divisive Opponents argue that a competition approach to medical treatment negatively impacts on quality while advocates point to increased efficiencies This book casts a critical eye over both positions to show that the concerns over quality are in fact real Taking a two part approach it unveils the fault lines along which healthcare provision and the pursuit of quality would in certain cases clash It then shows how competition authorities can only effectively assess competition concerns when they ask the fundamental question of how the concept of healthcare quality should be defined and factored into their decisions Drawing on UK US and EU examples it explores antitrust and merger cases in hospital medical and health insurance markets to give an accurate depiction of the reality and challenges of regulating competition in healthcare provision The Report of the Morecambe Bay Investigation Bill Kirkup, Morecambe Bay Investigation, 2015 For the great majority pregnancy and childbirth should be a positive and happy experience that culminates in a healthy mother and baby This means however that on those occasions when things do go wrong the effects are even more devastating than in other areas of healthcare Maternity care must reconcile these dual aspects in order to be safe effective and responsive When it does not the consequences may be stark This Report details a distressing chain of events that began with serious failures of clinical care in the maternity unit at Furness General Hospital part of what became the University Hospitals of Morecambe Bay NHS Foundation Trust The result was avoidable harm to mothers and babies including tragic and unnecessary deaths What followed was a pattern of failure to recognise the nature and severity of the problem with in some cases denial that any problem existed and a series of missed opportunities to intervene that involved almost every level of the NHS These events

have finally been brought to light thanks to the efforts of some diligent and courageous families who persistently refused to accept what they were being told Those families deserve great credit This Report includes detailed and damning criticisms of the maternity unit the Trust and the regulatory and supervisory system This Report sets out why that is and how it could have been avoided *Parliamentary Debates (Hansard)*. Great Britain. Parliament. House of Commons,2013 **The Stationery Office Annual Catalogue** Stationery Office (Great Britain),2014 **Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry**,2007 The Parliamentary Debates (Hansard). Great Britain. Parliament. House of Lords,2013 **The Mid Staffordshire NHS Foundation Trust Public Inquiry - Chaired by Robert Francis QC.** Sarah Harvey,2011 **Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry**,2013

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