The long-awaited Francis Report was published formally on Wednesday 6th February 2013. This is over 1,700 pages of evidence, analysis, and recommendations, which portrays an insight into an NHS Trust during 2004 to 2009 and highlights its failing in relation to patient care and culture.

Julie Bailey is the founder member of a group called ‘Cure the NHS’ and spent 2 years campaigning for a public enquiry into the failings at Mid Stafford Hospital after her mother, Bella Bailey, 86, died at the hospital in 2007. The campaign was launched after Ms Bailey witnessed 8 weeks of elderly care in this hospital. The ‘Cure the NHS’ web site states that ‘what we saw after the first few days left us fearing for my Mother’s life and too frightened to leave her. We stayed by her side sleeping on a chair for the first four days without a blanket, on the fourth night a nurse took pity and gave us one. What we saw horrified us and from the letters we have received, it haunts many others who have had relatives/friends on those wards. Some relatives have spent longer staying in the hospital than us and have shared their experiences. Most of the letters relate to wards 10, 11 and 12 and it is ward 11 where my Mother spent her last days’.

Many of the findings into the failings at Mid Staffordshire NHS Foundation Trust came as little surprise; early speculation was that report would highlight systemic failings within the NHS and that radical changes would be recommended.

Within the 226 page summary are 290 recommendations, a summary of the key recommendations are as follows:

- There should be a single regulator dealing with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts.
- There should be a legal duty of candour so that healthcare organisations have to admit their mistakes.
- There should be more powers to prosecute boards and individuals.
- Nurses to be held personally and criminally accountable for the care that they provide to their patients.
- GPs should undertake monitoring of their patients who attend/receive care from acute or specialist hospitals.
- Hospital boards should face dismissal if they fail to ensure minimum standards of safety and quality care.
- Only registered people should care for patients.
- Gagging orders should be banned.
- Subject to anonymisation, a summary of each upheld complaint relating to patient care should be published on its website.
- The transfer of functions of regulating governance of healthcare providers and the fitness of persons to be directors, governors or equivalent persons from Monitor to the Care Quality Commission.
- Those with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.

In addition to the scope and scale of the Francis Report, on its release there was a press announcement stating that five more hospitals were now being placed under investigation. A further five hospital trusts are to be investigated over high death rates following a scathing report which laid bare the "disaster" of Stafford Hospital. NHS Commissioning Board (NHS CB) medical director Professor Sir Bruce Keogh is to launch an immediate investigation into five trusts which had higher-than-average death rates for the last two years.
NHS trusts are immediately being scrutinised and investigated in a more robust way to prevent this appalling and preventable suffering from ever happening again. The full report has patient stories peppered throughout it. These talk of patients being left for hours sitting in their own faeces, food and drink left out of reach, and hygiene so poor that relatives had to clean toilets themselves.

The Francis Report is still not complete, the Department of Health will respond to the recommendations in the next month, and there is uncertainty about how the recommendations of the report fit with the existing reforms and how they can and should be implemented. However it is clear that patient safety needs addressed in the most open and honest way.

Speaking in the Commons after the report was released, the Prime Minister announced a raft of changes designed to ensure that any future failures in NHS organisations are identified and dealt with quickly. He ordered the creation of the post of Chief Inspector of Hospitals, who will have responsibility for a regime of inspections.

The ability of this group (Cure the NHS), made up of patients’ family and carers, to initiate such an in-depth investigation and potentially change the practices and culture of the NHS, should not be underestimated. With the increased focus on patient feedback and the ‘Friends and Family’ test the Board is reminded that patient perception and comments must be given a high priority.

When the DoH releases it response to the report we as a Trust will be implementing an action plan in line with the response and the recommendations of the report. Some work has already started, in that we are planning to strengthen our complaints and PALs service and staffing levels are being formally tested again, using the safer nursing care tool.