Department of Health

Hard Truths

The Journey to Putting Patients First

Volume One of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry

2 volumes not to be sold separately
Cm 8777-I

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Volume One of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

January 2014

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Foreword by the Secretary of State for Health

Many times over the last 12 months I have had the privilege of working alongside dedicated NHS staff as, day and night, they delivered to their patients safe, effective and compassionate care. Seeing the best of NHS care first hand has been inspiring.

But I have also met patients and families who have been very badly let down. I have had to respond to disturbing and depressing letters from people first failed by the NHS and then frustrated by the system when they seek answers and redress.

In considering the Government's response to Robert Francis QC's landmark Inquiry into Mid Staffordshire, both in broad terms and in the detail of each recommendation, I have had in my mind those two contrasting NHS stories – of care and compassion on the one hand and of failure and cover-up on the other.

For me, both the Inquiry and this full Government response underline some simple key messages for everyone working in the health and care system.

First, we need to hear the patient, seeing everything from their perspective, not the system's interests.

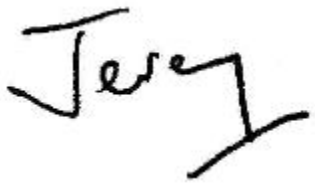
Second, we need to face up to the hard truths – from excellent to unacceptably poor – about what that system delivers for patients. This response sets out a series of measures that in the future will ensure people know what the system knows – whether hospitals are safe, how well they are led and what patients say about their experiences there. The new Chief Inspectors will tell the public the reality of NHS performance, without political or system interference, and trigger intervention when things need to be put right.

As a result of this response there will be stronger professional responsibility also, making clear the need to be open about mistakes and candid about 'near misses', following the example of the airline industry in building an open culture that learns from errors and corrects them.

Third, when things really go wrong, or on the rare occasions when leaders and Boards fail to show the integrity we all expect, the response will enable failing hospitals to be turned around and puts in place proper accountability, and, when necessary, criminal sanctions.

Finally, and critically, together the responses to the Inquiry's recommendations seek to build and strengthen a culture of compassionate care, looking to an NHS future in which world class leaders working with highly skilled and caring staff consistently strive to improve the care they give to patients. In doing so, in my discussions with NHS staff, I have found myself so often to be pushing at an open door.

I am profoundly grateful both to Robert Francis QC for the thorough and comprehensive report he has written and to the families and patients who campaigned for the Public Inquiry in the first place. This response seeks to build a future which learns the lessons of Mid Staffordshire so that NHS patients can confidently expect all the care they receive to be safe, effective and compassionate and when things do go wrong, lessons are learned quickly, and proper accountability is in place.



The Rt Hon Jeremy Hunt MP
Secretary of State for Health

Statement of Common Purpose

In the light of the findings of the report into the Mid Staffordshire NHS Foundation Trust Public Inquiry, we the undersigned make the following commitments.

1. **We renew and reaffirm our personal commitment and our organisations' commitment to the values of the NHS, set out in its Constitution**:

- **Working together for patients**[1]. Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.
- **Respect and dignity**. We value every person – whether patients, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.
- **Commitment to quality of care**. We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.
- **Compassion**. We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.
- **Improving lives**. We strive to improve health and well-being and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.
- **Everyone counts.** We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that

1 As the tragic events the Inquiry investigated occurred in a hospital, this statement refers to 'patients'. These principles and commitments apply equally to people in other care settings.

some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

2. **We apologise to every individual affected by this deeply disturbing and tragic failing in a service that means so much to us all.** What happened in Mid Staffordshire was, and is, unacceptable and collectively we take responsibility for putting things right. We recognise that while the depth, scale and duration of the failings at this hospital were unprecedented, we accept that every day the NHS is responsible for care that is poor as well as care that is good or excellent. **Our commitment to the NHS and our pride in the good that it does each day will not blind us to its failings.** It compels us to resolve them.

3. **We will put patients first**, not the interests of our organisations or the system. **We will listen to patients**, striving to ensure the quality of care that we would want for ourselves, our own families and our friends.

4. **We will listen most carefully to those whose voices are weakest and find it hardest to speak for themselves**. We will care most carefully for the most vulnerable people – the very old and the very young, people with learning disabilities and people with severe mental illness.

5. **We will work together**, collaborating on behalf of patients, combining and coordinating our strengths on their behalf, sharing what we know and taking collective responsibility for the quality of care that people experience. **Together, we will be unfailing in rooting out poor care and unflinching in promoting what is excellent.**

6. Whilst this poor care was in a hospital, poor care can occur anywhere across the health and social care system. Whether in a care home, at the family doctor, in a community pharmacy, in mental health services, or with personal care in vulnerable people's homes, **we will ensure that the fundamental standards of care that people have a right to expect are met consistently, whatever the setting.**

7. **Every one of us commits to ensuring a direct connection to patients and to the staff who care for them**. We will ensure that our organisations and our staff look outwards to the people they serve, taking decisions with patients and local communities at the forefront of their minds. **We will shape care in equal partnership with the people who depend on it.** We will do the business of the patient, before that of our organisation or the system.

8. **We will work together to minimise bureaucracy, enabling time to care and time to lead, freeing up the expertise of NHS staff and the values and professionalism that called them to serve.** Caring is demanding as well as rewarding, and depends on the personal and professional values of everyone who works in the NHS. We know well-treated staff treat patients well, so as the NHS become busier we need to ensure time to care and time to recover from caring. We will recruit, appraise and reward staff for their care, as well as their skills and their knowledge.

9. Healthcare is complex and we are part of a complicated system. Building on a foundation of fundamental and inviolable standards, **we will build a single set of nationally agreed and locally owned measures of success, focussed on what matters most to patients.** They must be credible and independently assessed so that patients, the public, parliament and those who work for NHS patients have a single version of the truth about local services

and organisations and their staff have a single set of standards of care to which they aspire. **Targets or finance must never again be allowed to come before the quality of care.** We need to use public money well and we need to be efficient and productive, but these are a means to an end – safe, effective and respectful care, compassionately given. We will be balanced in what we do and what we expect, with the patient interest at the heart of it. We must all do our best to maintain and raise quality within the resources we have.

10. We believe that patients are best served and our values nurtured by a spirit of candour and a culture of humility, openness, honesty and acceptance of challenge. Things do go wrong, but when they do we must learn from mistakes, not conceal them. **We will seek out and act on feedback, both positive and negative.** We will listen to patients who raise concerns, respond to them and learn from them. We will listen to staff who are worried about the quality of care, praising them for doing so, even if a concern was misplaced. **We have a duty to challenge ourselves and each other on behalf of patients and we will do so.**

11. Signing up to principles in offices in national organisations is easy. **Changing ourselves, our behaviour, individually and institutionally, is difficult, but we pledge to do so.** Health and care is not like any other job. It touches the hearts of people's lives, can do immense good but also immense harm – it is a matter of life or death. This is both a privilege and a great responsibility. Together, we will make ourselves accountable and responsible for what we do, not what we say, in striving to make real, for every patient, the values to which we recommit ourselves today. Over the coming months, each us of us will set our plans for making these commitments a reality. In delivering those plans, we will be judged by the difference that they make to the people whom we serve.

12. The organisations signing this pledge have different responsibilities within our healthcare system, but whatever our role we pledge to learn the lessons from Mid Staffordshire, help to build better care for every patient and do everything in our power to ensure it does not happen again. We invite all organisations in the health and care system to join us in signing up to this statement of common purpose.

Signatories

David Prior, Chair, Care Quality Commission
Una O'Brien, Permanent Secretary, Department of Health
Professor Sir Peter Rubin, Chair, General Medical Council
Sir Keith Pearson, Chair, Health Education England
Sir Merrick Cockell, Chair, Local Government Association
Dr David Bennett, Chair, Monitor
Professor Malcolm Grant, Chair, NHS England
Michael O'Higgins, Chair, NHS Confederation and NHS Employers
Jan Sobieraj, Managing Director, NHS Leadership Academy
Sir Andrew Dillon, Chief Executive, National Institute for Health and Clinical Excellence
Sir Peter D Carr, Chair, NHS Trust Development Authority
Mark Addison, Chair, Nursing and Midwifery Council
Alan Perkins, Chief Executive, Health and Social Care Information Centre
Professor David Heymann, Chair, Public Health England
Charles Howeson, Chair, NHS Property Services Ltd

Executive Summary

'The extent of the failure of the system shown in this report suggests that a fundamental culture change is needed'

Robert Francis QC

1. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, published in February 2013, called for a 'fundamental culture change' across the health and social care system to put patients first at all times. Robert Francis QC, the Inquiry Chair, called for action across six core themes: culture, compassionate care, leadership, standards, information, and openness, transparency and candour.

2. The Government's initial response, *Patients First and Foremost*, set out a radical plan to prioritise care, improve transparency and ensure that where poor care is detected, there is clear action and clear accountability. This document and its accompanying volume build on this to provide a detailed response to the 290 recommendations the Inquiry made across every level of the system.

3. It also responds to six independent reviews which the Government commissioned to consider some of the key issues identified by the Inquiry:

- Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England.
- *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*, by Camilla Cavendish.
- *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*, by Professor Don Berwick.
- *A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture* by Rt Hon Ann Clwyd MP and Professor Tricia Hart.
- *Challenging Bureaucracy*, led by the NHS Confederation.
- The report by the Children and Young People's Health Outcomes Forum, co-chaired by Professor Ian Lewis and Christine Lenehan.

4. Since the Inquiry reported, the Government has already instigated a number of significant changes which will improve inspection, increase transparency, put a clear emphasis on compassion, standards and safety, increase accountability for failure, and build capability.

- The Care Quality Commission has appointed three **Chief Inspectors** of hospitals, adult social care and primary care.
- The Chief Inspector of Hospitals has begun a first wave of inspections of 18 Trusts.
- **Expert inspections of hospitals with the highest mortality rates**, led by the NHS Medical Director, revealed unacceptable standards of care. Eleven hospitals were placed into 'special measures' **to put them back on a path to recovery and then to excellence**.
- The Care Quality Commission has consulted on a **new system of ratings** with patient care and safety at its heart.
- Legislation to introduce a responsive and effective **failure regime** which looks at quality as well as finance is progressing through Parliament.
- The Government is legislating to give **greater independence to the Care Quality Commission**
- The Care Quality Commission has conducted a major consultation on a new set of **fundamental standards:** the inviolable principles of safe, effective and compassionate care that must underpin all care in the future. The **fundamental standards will enable prosecutions of providers** to occur in serious cases where patients have been harmed because of unsafe or poor care, without the need for an advance warning notice.
- NHS England has published guidance to commissioners, *Transforming Participation in Health and Care*, on **involving patients and the public** in decisions about their care and their services.
- For the first time, NHS England has **published clinical outcomes by consultant** for ten medical specialties and has also begun to publish data on the friends and family test.
- **New nurse and midwifery leadership programmes** have been developed from which 10,000 nurses and midwives will have benefitted by April 2015. *Compassion in Practice* has an action area dedicated to building and strengthening leadership.
- A new fast-track **leadership** programme to recruit clinicians and external talent to the top jobs in the NHS in England has been launched, including time spent at a world-leading academic institution.
- By the end of the year, 96% of **senior leaders and all Ministers at the Department of Health will have gained frontline experience in health and care settings**.

5. This document sets out how the whole health and care system will prioritise and build on this, including **major new action on the following vital areas**:

- **Transparent monthly reporting of ward-by-ward staffing levels and other safety measures**.
- All hospitals will clearly set out how patients and their families **can raise concerns or complain, with independent support available from local Healthwatch or alternative organisations.**
- Trusts will report quarterly on complaints data and lessons learned, and the Ombudsman will significantly increase the number of cases she considers.
- A statutory duty of **candour** on providers, and a professional duty of candour on individuals through changes to professional guidance and codes.
- The Government will consult on proposals about whether Trusts should reimburse a proportion or all of the NHS Litigation Authority's compensation costs when they have not been open about a safety incident.
- Legislate at the earliest available opportunity on **Wilful Neglect** – so that those responsible for the worst failures in care are held accountable.
- A new **fit and proper person's test** which will act as a barring scheme.
- All arm's length bodies and the Department of Health have signed a protocol in order to **minimise bureaucratic burdens on Trusts**.
- A new **Care Certificate** to ensure that Healthcare Assistants and Social Care Support Workers have the right fundamental training and skills in order to give personal care to patients and service users.
- The Care Bill will introduce a **new criminal offence applicable to care providers that supply or publish certain types of information that is false or misleading,** where that information is required to comply with a statutory or other legal obligation.

PREVENTING PROBLEMS

Culture

6. Patients and the public expect the NHS to do all it can to prevent any repetition of the terrible events at Mid Staffordshire NHS Foundation Trust. This requires a profound change in culture that means ensuring safe care for patients; treating people as partners; and supporting staff to care.

Patient Safety

7. This document sets out a range of new measures to take forward the findings of Professor Don Berwick's review and **make care safer for patients**, developing a culture that is dedicated to learning and improvement, and that continually strives to reduce avoidable harm in the NHS.

8. Following Don Berwick's recommendation, NHS England will establish a **new Patient Safety Collaborative Programme** across England to spread best practice, build skills and capabilities in patient safety and improvement science, and to focus on actions that can make the biggest difference to patients in every part of the country. The Safety Collaboratives will be supported systematically to tackle the leading causes of harm to patients. The programme will include establishing a **Patient Safety Improvement Fellowship** scheme to develop 5,000 Fellows within a national faculty within five years.

9. The Department of Health has agreed with the nursing and medical Royal Colleges and clinical leaders that **every hospital patient should have the name of the consultant and nurse responsible for their care above their beds.** The Government also intends to introduce a **named accountable clinician** for people receiving care outside hospitals, starting with vulnerable older people.

10. Patients and the public need easy access to reliable and accurate information about the safety of their hospital. **The Care Quality Commission and NHS England will work** with Monitor, Trust Development Authority, the Information Centre and others to make patient safety data more accessible to all and provide clear guidance on what it means – and does not mean. This includes issuing a joint statement from the Care Quality Commission and NHS England on their commitment to complete alignment of patient safety measurement and **developing a dedicated hospital safety website for the public which will draw together up to date information on patient safety factors, for which robust data is available.** This will include information on staffing, pressure ulcers, healthcare associated infections and other key indicators, where appropriate at ward level. The website will aim to begin publication from June 2014. It will, over time, become a key source of public information, putting the truth about care at the fingertips of patients and updated monthly.

11. Trusts will continue to be encouraged to use **NHS Safety Thermometer data collection to help inform improvements in some key patient safety areas: pressure ulcers, falls resulting from harm, catheter-associated infections and venous thromboembolism.** NHS England will work with the Care Quality Commission, Monitor, Trust Development Authority, the Health and Social Care Information Centre and others to make patient safety data more accessible to all and provide clear guidance on what it means – and does not mean.

12. NHS England will begin to **publish 'never events' data quarterly before the end of 2013, and then monthly from April 2014** to help Trusts, patients and the public drive improvement of services.

13. NHS England will **re-launch the patient safety alerts system by the end of 2013** in a clearer framework that will support organisations to understand and take rapid action in relation to patient safety risks. This new system will include greater clarity about how organisations can assess their compliance with alerts and other notifications and ensure they are appropriately implemented.

Openness and candour

14. The Government will consult on proposals about whether Trusts should reimburse a proportion or all of the NHS Litigation Authority's compensation costs when they have not

been open about a safety incident. Subject to Parliamentary approval, from 2014 every organisation registered with the Care Quality Commission will be expected to meet a **new duty of candour. Where the NHS Litigation Authority finds that a Trust has not been open with patients or their families about a patient safety incident which turns into a claim, it could have the discretion to reduce or remove that Trust's indemnity cover for that claim. The NHS Litigation Authority will continue to make compensation payments due to patients.** Trusts who were not open with their patients could be required to reimburse the NHS Litigation Authority for a proportion or all of the payment.

15. In addition to the statutory duty of candour on providers, there is also a **professional duty of candour on individuals that will be strengthened** through changes to professional guidance and codes. The professional values of individual clinicians are critical in ensuring an open culture in which mistakes are reported, whether or not they cause actual harm. The General Medical Council, the Nursing and Midwifery Council and the other professional regulators will be working to agree consistent approaches to candour and reporting of errors, including a **common responsibility across doctors and nurses, and other health professions to be candid with patients when mistakes occur whether serious or not, and clear guidance that professionals who seek to obstruct others in raising concerns or being candid would be in breach of their professional responsibilities**. We will ask the Professional Standards Authority to advise and report on progress with this work. **The professional regulators will develop new guidance to make it clear professionals' responsibility to report 'near misses' for errors that could have led to death or serious injury, as well as actual harm, at the earliest available opportunity and will review their professional codes of conduct to bring them into line with this guidance. The professional regulators will also review their guidance to panels taking decisions on professional misconduct to ensure they take proper account of whether or not professionals have raised concerns promptly.**

Listening to patients

16. Listening to patients and the public and responding to what they say is at the heart of a compassionate healthcare system. Patients must be involved and given their say at every level of the system.

17. **The NHS Constitution** sets out in one place the rights that all patients should expect when they receive care, and which govern how NHS organisations must behave. NHS England, Clinical Commissioning Groups, Health Education England and the Department of Health are working together with others, including NHS staff and patients, to develop a joint strategy to embed the NHS Constitution in everything that the NHS does.

18. Following successful implementation in acute hospitals, **the use of the friends and family test will be extended to mental health settings by the end of December 2014.** This will allow patients and staff the chance to raise concerns about standards of care in their hospitals, quickly and effectively.

19. By December of this year 80% of clinical commissioning groups will be commissioning **support for patients' participation and decisions in relation to their own care.**

20. It is important that local Healthwatch, as the patient and public champion for health and care services, should be as strong and effective as possible so that it can speak up for patients and provide independent support on complaints. **Healthwatch England and the Local Government Association have recently launched a tool to help local areas identify what outcomes and impacts a good local Healthwatch could achieve.**

21. At a national level, **the Care Quality Commission is now involving patients in its inspections to inform its ratings of hospitals.** The three Chief Inspectors will use the insights of people who use services to guide, inform and influence the inspection process and the judgements that come out of it.

22. Improving that the way in which the NHS manages and responds to **complaints** will be critical in shaping a culture that listens to and learns from patients, and ending a culture of defensiveness, or at worst, denial about poor care and harm to patients. The Government welcomes the review of the NHS Hospitals Complaints System by Rt Hon Ann Clwyd MP and Professor Tricia Hart, and accepts the principles behind the recommendations.

23. The Government wants every hospital to promote a culture of openness and encourage feedback, **making it clear to patients, their families and carers – for example through a sign on every ward and clinical setting – how they can complain, how to get independent local support and informing them of their right to complain to the Ombudsman if they remain dissatisfied**. Trust Chief Executives and Boards will be expected to take personal responsibility for complaints, for example by signing off letters and through an update at each board meeting. **Detailed information on complaints and the lessons learned will be published quarterly.** This will include the number of complaints received as a percentage of patient interventions, the number of complaints the hospital has been informed have subsequently been referred to the Ombudsman and the lessons learned and improvements made as a result of complaints. The Care Quality Commission will look closely at how well a Trust deals with complaints and the Government welcomes the commitment of the Ombudsman to significantly expand the number of cases she considers.

24. The Government will explore with NHS England and other key partners the introduction of a regular and standard way of asking people who have made a complaint about whether they were satisfied with the way it was handled- to enable comparison across hospitals.

Safe staffing

25. Building on the Compassion in Practice action area dedicated to ensuring the right staff, at the right time and with the right skills, **the National Quality Board and the Chief Nursing Officer are publishing a guidance document that sets out the current evidence on safe staffing**. **This clarifies** the expectations on all NHS bodies to ensure that every ward and every shift has the staff needed to ensure that patients receive safe care.

26. By Summer 2014, **the National Institute of Health and Care Excellence will produce independent and authoritative evidence based guidance on safe staffing, and will review and endorse associated tools for setting safe staffing levels in acute settings. The National Institute for Health and Care Excellence will then start work to develop similar guidance and endorsement for staffing in non-acute settings, including mental health, community and learning disability services.**

27. From April 2014, and by June 2014 at the latest, **NHS Trusts will publish ward level information on whether they are meeting their staffing requirements**. **Actual versus planned nursing and midwifery staffing will be published every month; and every six months Trust boards will be required to undertake a detailed review of staffing using evidence based tools**. The first of these will take place by June 2014 and Trusts will be required to set out what evidence they have used to reach their conclusions. The second review, to be undertaken by December 2014, will use National Institute for Health and Care Excellence accredited tools. A review every six months will allow for the collection of several data points to inform appropriate staffing. Commissioners will use staffing data as a basis for further questions and discussions with providers.

28. The Care Quality Commission through its Chief Inspector of Hospitals will monitor this performance and take action where non-compliance puts patient at risk of harm and **appropriate staffing levels will be a core element of the Care Quality Commission's registration regime.**

29. Health Education England has been working with NHS trusts to develop the overall workforce plan for England for 2014-15, reflecting strategic commissioning intentions. **This work indicates that a number of trusts have already increased their nurse staffing levels during 2013-14 and others are planning to do so**. Initial plans indicate that Trusts intend to employ an increase of over 3,700 nurses in 2013-14.

30. The Department of Health has commissioned a programme of work from NHS Employers that will provide **tools and training for employers to support the engagement, health and well-being of their staff.**

31. A culture that prevents poor care before it occurs depends critically on the values of the people who work in the healthcare system. As set out in its mandate, **Health Education England is committed to introducing values-based recruitment for all students entering NHS-funded clinical education programmes.**

DETECTING PROBLEMS QUICKLY

32. The new Chief Inspector of Hospitals, Professor Sir Mike Richards has issued a 'call to action' to draw patients and doctors, nurses and other health professionals into **expert inspection teams**. In July 2013, 5,025 clinicians and 2,446 patients offered to take part in inspections. Inspectors will spend more time listening to patients, service users and the staff who care for them. Inspection will include a closer examination of records, and crucially, **inspections visits will also take place at night and at weekends, with more unannounced inspections**.

33. From January 2014, the Care Quality Commission will **rate hospitals' quality of care in bands ranging from outstanding to inadequate.** The three Chief Inspectors will use the insights of people who use services to guide, inform and influence the inspection process and the judgements that come out of it.

34. To give patients and the public confidence that problems are being sought out and dealt with, **by the end of 2015 the Care Quality Commission will have conducted inspections of all acute trusts**. Two waves of inspections have been announced. The first wave of 18

Trusts is under way and will be completed by Christmas 2013, with a second wave of 19 Trusts starting in January 2014. This will include **re-inspecting the 14 hospitals investigated by the Keogh Review of mortality outliers,** to assure itself that good progress is being made in improving the standard of care for patients.

35. In mental health, inspection will begin with wave one pilots in January to March 2014; followed by a second wave in April to June 2014. Ratings will be published from October 2014 for the NHS and January 2015 for the independent sector.

36. In adult social care, inspection will begin with wave one pilots in Spring 2014 followed by a second wave in Summer 2014. All social care services will have been rated by March 2016.

37. The Department of Health and the Care Quality Commission are developing for consultation the **fundamental standards** recommended by the Inquiry. They will be described in clear, unambiguous language, expressed in terms of what it means to patients and service users.

38. The Care Quality Commission has reviewed how it uses information to identify potential failures in the quality of care in hospitals. It will ask five key questions **– is a service safe, effective, caring, responsive and well led**? The fundamental standards, below which care should never fall, will be complemented by more stretching enhanced and developmental standards which commissioners will use to require providers to deliver services to patients and service users that are of a higher quality, and the Care Quality Commission will use to inform their ratings.

39. **The Government is legislating to enhance the independence of the Care Quality Commission to ensure there can be no political interference in its vital work to protect patients.**

40. The Secretary of State has made clear that so-called 'gagging orders' are unacceptable. NHS staff will be able to raise concerns about patient care in the knowledge that they will be listened to and their views will be welcomed. The new Chief Inspector of Hospitals will be judging **whether the culture of the organisation actively promotes the benefits of openness and transparency**; and staff **can now blow the whistle to their health and care professional regulatory bodies**. All healthcare professionals will be protected by the provisions of the Public Interest Disclosure Act 1998. **Compromise agreements must include an explicit clause making clear that nothing within the agreement prevents disclosure under the Act. NHS England will develop a friends and family test for staff** and the 'Cultural Barometer' is being piloted and evaluated prior to a potential further roll out.

41. Robert Francis found that there was a lack of communication and understanding between the different organisations that held responsibility for providing oversight, support and challenge to Mid Staffordshire NHS Foundation Trust. New arrangements for regulators and commissioners will ensure that the distinct roles and responsibilities, as well as the issues and areas they need to co-operate on, are clear and unambiguous. This includes structures for sharing information and joint decision-making where they are needed. The Care Quality Commission will focus on assessing quality and publishing its findings rather than intervening to drive improvement – which falls to the NHS Trust Development Authority and Monitor.

42. **Quality Surveillance Groups** have been in place since April 2013. Their role is to bring together all key organisations at a local level to share information to make judgements based on soft information and intelligence about the quality of care at hospitals where there are concerns about care standards. Once concerns are identified, action can be taken swiftly by the relevant organisation.

TAKING ACTION PROMPTLY

43. For more significant concerns where providers are unable to improve without further support, regulatory oversight will be required. **Clear, meaningful ratings will be accompanied by clear, risk-based intervention. For the first time, the NHS will have an effective failure regime that addresses quality as well as financial distress and failure.** This will give patients and the public confidence that action can be taken quickly when services are not performing well enough.

44. Expert inspection against standards, informed by hard data and soft intelligence, will enable the Care Quality Commission through its Chief Inspectors to make judgements about whether providers are:

- **Outstanding:** sustained high quality care over time across most services, together with good evidence of innovation and shared learning.
- **Good:** the majority of services meet high quality standards and deliver care which is person centred and meet the needs of vulnerable users.
- **Requires Improvement:** significant action is required by the provider to address concerns.
- **Inadequate:** serious and/or systematic failings in relation to quality.

45. **Trusts aspiring to Foundation Trust status will have to achieve 'good' or 'outstanding' under the Care Quality Commission's new inspection regime to be authorised.** Monitor and the Care Quality Commission will also implement a joint registration and licensing system in April 2014.

46. The regulatory regime will be based around a **'single version of the truth' grounded in standards and ratings through inspection**. Under the single failure regime, clinical unsustainability will be grounds for failure procedures, including placing organisations in special measures, just as financial unsustainability is at present. Care Quality Commission, NHS England, Monitor and the NHS Trust Development Authority will publish further guidance on how they will work together to address quality issues after April 2014. **Where a Foundation Trust is placed in special measures, it will have its freedom to operate as an autonomous body suspended.** This will provide a basis for tailored and proportionate intervention that puts patients first and puts things right promptly.

47. In October 2013, Monitor introduced a **Risk Assessment Framework for NHS Foundation Trusts** which will allow Monitor to track risk and trigger enforcement action. In April 2013, the NHS Trust Development Authority published *Delivering high quality care for patients: The accountability framework for NHS Trust Boards* which sets out its approach to the oversight of and intervention in NHS Trusts.

48. Monitor published **enforcement guidance** in March 2013 on how it plans to obtain compliance in Foundation Trusts where there are breaches of health care standards specified by the Care Quality Commission, NHS England and statutory regulators of health care professions.

49. Where an NHS Trust or Foundation Trust has been placed into special measures by the NHS Trust Development Authority or by Monitor, **the Board of the Trust will need to demonstrate to the relevant body that it is credibly and effectively addressing the issues that have been raised.**

50. Where cases of failure cannot be resolved at local level, either by the Trust Board or local commissioners supported by NHS England, the use of **special administration provides a mechanism for ensuring that issues are addressed as a last resort.** Under special administration, the Secretary of State (in the case of an NHS Trust) or Monitor (in the case of a Foundation Trust) replaces the Trust's Board with a special administrator. Proposals in the Care Bill are designed to ensure that this action can be taken in cases of clinical as well as financial unsustainability.

ENSURING ROBUST ACCOUNTABILITY

51. Putting in place a clear and well-functioning system of accountability in the NHS is a critical condition for creating a culture of safe, compassionate care. In addition to the ratings and inspections led by the Care Quality Commission through its Chief Inspector of Hospitals, the Boards of Trusts are responsible for both holding their own organisation to account and accounting to the public about its performance. **NHS organisations and all parts of the health and care system will be more accountable than ever before.**

52. **NHS England will hold clinical commissioning groups to account for quality and outcomes and for their financial performance, and will have the power to intervene where there is evidence that they are failing, or are likely to fail, in their functions.** Local commissioners of health, care, and other services have a new opportunity, through health and wellbeing boards, to work in partnership together to improve outcomes for the whole population.

53. There will be a new stronger **fit and proper persons test** for Board level appointments which will enable the Care Quality Commission to bar directors who are unfit from individual posts at the point of registration. This will apply to providers from the public, private and voluntary sectors. The Government believes that the barring mechanism will be a robust method of ensuring that directors whose conduct or competence makes them unsuitable for these roles are prevented from securing them. The scheme will be kept under review to ensure that it is effective, and we will legislate in the future if the barring mechanism is not having its desired impact.

54. There must also, on occasion, be **direct consequences for senior managers for failures in their organisations**. NHS Employers will therefore be commissioned to work with the Care Quality Commission, the NHS Trust Development Authority and Monitor to develop guidance to support the effective performance management of very senior managers in

hospitals through appraisal and other means, including linking the Chief Inspector's ratings to individual contracts.

55. The Government agrees with Professor Don Berwick's recommendation that there should be a new criminal offence 'in the very rare cases where individuals or organisations are unequivocally guilty of **wilful or reckless neglect** or mistreatment of patients'. This will help to ensure that there is ultimate accountability for those guilty of the most extreme types of poor care. The Government will seek to legislate on this, will work with stakeholders beforehand to determine the details of this measure, and will consult on proposals for legislation as soon as possible.

56. Subject to Parliament, the Care Bill proposes a new criminal offence applicable to care providers who supply, publish or otherwise make available certain types of **information that is false or misleading**, where that information is required to comply with a statutory or other legal obligation. The Bill also proposes that this offence will apply to the 'controlling minds' of the organisation, where they have consented or connived in an offence committed by a care provider.

57. **In April 2013, Monitor published a guide for Boards on how to ensure organisations are working effectively to improve patient care.** Monitor will also be publishing an updated Code of Governance for Foundation Trusts in early 2014 which will make recommendations to strengthen corporate governance in light of the Inquiry report. There are also plans for regular governance reviews of foundation trusts which will include quality governance

58. The professional regulatory bodies are currently hampered by a cumbersome and complex inheritance of legislation. The **Government will seek an early opportunity to legislate, enabling all the professional regulators to move rapidly to a maximum 12 month period for concerns raised about professionals to be resolved or brought to a hearing, in all but a small minority of cases.**

59. As the **medical revalidation** programme is making good progress and is working effectively in practice, we are now at the right point for **transferring the programme to NHS England** to take forward and lead the continued implementation across England.

60. **Commissioners** have a vital role to play in securing safe, compassionate care for the populations they serve. Clinically-led commissioning groups, by **putting doctors, nurses and other health professionals at the heart of commissioning with an explicit focus on improving health outcomes for the whole population,** will provide a robust basis for effective commissioning. They will be supported by **strategic clinical networks and clinical senates.**

61. Ultimate responsibility for the NHS rests with the **Government**, and the Department of Health is committed to implementing the specific recommendations that Robert Francis directed at Government. Through the **'connecting'** programme, departmental civil servants and Ministers are gaining direct experience of the realities of care services at the point of care.

ENSURING STAFF ARE TRAINED AND MOTIVATED

62. Well-treated staff treat patients well. A wealth of academic evidence demonstrates that effective **staff engagement** is absolutely essential for creating positive cultures of safe, compassionate care. The Department of Health has asked the **Social Partnership Forum**, which brings together representatives of staff and employers in the NHS, to produce guidance on good staff engagement.

63. Education and training are critical to securing the culture change necessary for the best patient care now and in the future. Action led by Health Education England and other organisations will focus on ensuring improvements in **continuous professional development and appraisal**. This will support NHS staff to prioritise the quality of care, work effectively in **multi-disciplinary teams**, to be compassionate, safety-conscious, and to genuinely listen to their patients and service users.

64. Improving the quality of **nursing** and the support available to nurses in the difficult and challenging work that they do to look after patients is at the heart of the response to the Francis report. We will continue to implement **Compassion in Practice and the 6 Cs,** fostering **nurse leadership** and supporting the implementation of **nurse revalidation.**

65. A key test of whether we have got safe, compassionate care right is the care we provide for older people, who can often be the most vulnerable patients, and those most in need of care that is properly joined up and well managed. Health Education England, working with the Chief Nursing Officer, the Director of Nursing at the Department of Health and Public Health England and the nursing profession, will develop a bespoke **older persons' nurse post-graduate qualification training programme.**

66. Health Education England has established the first set of pilots of up to one year of **pre-degree care experience for aspiring student nurses**. On completion the pilot will be evaluated to see how pre-degree care experience could be rolled out in an affordable and cost-neutral way, so that everybody who wants to train to be a nurse is able to gain caring experience before they start their studies.

67. The Nursing and Midwifery Council has committed to introduce an affordable, appropriate and effective model of **revalidation** for the nursing and midwifery professions to enhance public protection and continue to improve the quality of nursing for patients.

68. The review undertaken by Camilla Cavendish raised the need to improve recruitment, training, development and supervision of health and social care support workers, building on the work of Health Education England around the work on Agenda for Change Bands 1-4 and the publication by Skills for Care and Skills for Health of the National Minimum Training Standards in March 2013 to develop minimum standards for health care assistants and support workers. The Government has asked Health Education England to lead the work with the Skills Councils, and other delivery partners to develop a new **Care Certificate** to ensure that Healthcare Assistants and Social Care Support Workers have the right fundamental training and skills in order to give personal care to patients and service users.

69. One of the most powerful ways we can support staff to improve outcomes for patients and to enjoy more fulfilling work is to find ways of cutting back on **burdensome bureaucracy**

in order to release 'time to care'. The bureaucracy review led by the NHS Confederation, recommends three main ways to reduce unnecessary burden by understanding, reducing and actively policing the volume of requests from national bodies; by reducing the amount of effort it takes providers to respond to information requests; and by increasing the value derived from information that is collected.

70. NHS England has introduced a **Clinical Bureaucracy Index and Audit of Digital Maturity in Health and Care** to support trusts in tracking how well they are using digital technology to reduce the burden of information collection on front line staff compared to their peers. Additionally, the Department of Health and every arm's length body signed a **Concordat for reducing the administrative burden arising from national requests for information**. The concordat aims at ensuring that national requests for information are undertaken using a single transparent process and that there are significant year on year reductions in the cost and burden caused by requests for information to the front line.

71. Excellent **leadership** is critical to the delivery of quality care. Patients need the NHS to have appropriately skilled leaders, with the right values, behaviours and competencies, at every level of the system. The development programmes of the NHS Leadership Academy will support a range of NHS staff (including clinical staff) to lead their teams and organisations to achieve more compassionate care for patients. **A new fast-track leadership programme** will attract senior clinicians as well as fresh talent from outside the NHS to manage NHS hospitals following an intensive programme of direct experience and time spent in a leading academic institution.

CONCLUSION

72. **Improving care is the responsibility of all organisations and all individuals in the NHS**. When we published *Patients First and Foremost*, we asked Trusts to hold listening events and set out for their local communities what they are doing to improve services for patients. It is encouraging that many Trusts have considered the Inquiry report in public Board meetings, and have held listening events. We have asked for feedback on these events by the end of 2013 but would urge organisations to continue such conversations to understand the concerns of their patients and staff and identify areas for improvement.

73. Across the health and care system, staff want to deliver safe, effective and compassionate care, to feel safe to raise any concerns, and to have confidence that these will be tackled. This response is of necessity detailed in order to do justice to the insightful findings of a major public inquiry. Within this complexity, however, it is important never to lose sight of the simple messages at the core of changing culture: **hear the patient, speak the truth, and act with compassion**.

Introduction: Changing culture

'What is required now is a real change in culture, a refocusing and recommitment of all who work in the NHS – from top to bottom of the system – on putting the patient first. We need a common patient centred culture which produces at the very least the fundamental standards of care to which we are all entitled, at the same time as celebrating and supporting the provision of excellence in healthcare'.

Robert Francis QC

1. No one joins the NHS to deliver anything other than exceptional care. But NHS staff are often faced with a system that can sometimes make that difficult, or even impossible. This response includes many measures to address that, but fundamentally requires a deep-rooted change of culture that always puts patients first.

2. Nobody who reads Robert Francis's report of the Mid Staffordshire NHS Foundation Trust Public Inquiry can think that the terrible failings in professional conduct, leadership, safety and compassion at Mid Staffordshire were simply the result of one organisation losing its way. The wider system, a system whose primary purpose was to support the delivery of safe, effective care, and to act when that did not happen, failed as well. It did not see, or did not want to see what was going on in Mid Staffordshire.

3. Patients and the public want to know how this could ever have been allowed to happen. They also want to know whether Mid Staffordshire was an isolated case or whether other hospitals or services are failing their patients as Mid Staffordshire did. They want to know what will be done to prevent such terrible failings in care from happening again.

4. It is important to underline the fact that the vast majority of NHS staff and the organisations they work for are dedicated and committed to improving the care they offer. But it would be wrong to use this to justify complacency, or to permit a sense that the problems of Mid Staffordshire were something that happened 'over there' and 'back then'.

5. Many organisations in the NHS are already rejecting any such complacency, and are rising to the challenge of changing the culture of the NHS. They are using the Inquiry report to ask searching questions about their own practice and ways of working. The pledges made by individual NHS staff as part of **NHS Change Day** show that the response to the Inquiry report by people at or close to the point of care is, in very many cases, practical and positive.[i]

6. One of the key lessons that is emerging from both the practical, on-the-ground thinking being done by NHS practitioners and organisations and from the research evidence is that **even the most high-performing organisations can have areas of care that need**

improvement and which sometimes fall below acceptable standards. Research carried out for the Department of Health to assess the cultures of NHS organisations in England found 'considerable variability in how far organisations succeeded in making their aspirations for high-quality care real: … 'bright spots' and 'dark spots' were both evident, even within the same organisations.'[ii]

7. While the remit of the Inquiry into Mid Staffordshire NHS Foundation Trust was explicitly limited to the NHS, the Inquiry's recommendations resonate across the health and care system as a whole. Beyond the detail of the 290 recommendations made in response to the specific issues he found, Robert Francis talks more generally in terms of key themes, under an overarching need for cultural change. Our response concentrates on the NHS where Francis made his recommendations, but we have also carefully considered the extent to which the reform programme set out in *Caring for the Future* and the Care and Support Bill addresses these themes in social care. It is only by getting things right across the system, from people's own homes, to consulting rooms and wards all the way through to boardrooms and to those organisations that provide external support and challenge, that we can hope to continually improve our culture.

8. Our response applies equally to mental health and physical health services. The Government has enshrined in law the equal importance of mental health and physical health, and we have made improving mental health and treating mental illness a key priority.

9. Culture change from within the NHS that puts patients first needs to be reinforced and supported by the use of **standards and inspection**. The Care Quality Commission through its Chief Inspector of Hospitals and his team of expert inspectors will apply a rigorously objective and searching approach to assessing the quality of care, without fear or favour. They will focus on the importance of an organisation being 'well led', looking closely at the culture and leadership of hospital trusts. In making this assessment, the Chief Inspector will draw on a wide range of evidence, including the views of patients and staff.

10. More than ever, it is vital for the NHS to commit to a culture of **continuous improvement** in order to both reduce variation and improve overall quality of care. Much of the drive for this will come from within NHS organisations themselves, but the Government is also committed to creating a framework in which excellence is rewarded, failure is addressed and mediocrity is challenged. For some NHS hospital trusts, this may well be an uncomfortable process, but as we have seen in recent years in the relationship between OFSTED and schools, improvement can be driven by a robust inspectorate and clear standards.

11. A new culture of safe, compassionate care has to be built on **candour, honesty and openness.** After Mid Staffordshire and after the Inquiry's report, the instinct of NHS organisations at both local and national levels and of Government to 'assure first and ask questions in private later' simply will not wash with the public. A new openness is not just a 'National Institute for Health and Care Excellence idea', it is the basic and rightful expectation of the public, and without it the leading organisations of the NHS simply will not be taken seriously, and will fail to restore full public trust in the NHS.

12. This means being honest about variations in the quality of care. The quality of care varies. It varies between hospitals and between other care organisations. It varies within those

organisations, between services, between wards, between shifts and between individual practitioners. If we cannot face the facts that the public know to be true from their own experiences, it will not be possible to have a meaningful conversation with them about the future of the NHS. To be clear: it is both true that most care provided by the NHS and by adult social care organisations is good or better, but also that quality of care can vary. It has always varied, but what is now different is that this variation is increasingly visible to all. Being honest and open about this and **creating an environment in which problems are prevented, detected quickly and addressed firmly and in the interests of patients is the basis for re-establishing public trust** after the appalling events at Mid Staffordshire NHS Foundation Trust, and in other health and care settings such as Winterbourne View.

13. **The Government and the national organisations that have signed this response accept the Francis report**. Where we disagree with any of the specific recommendations in the Inquiry report, or where the relevant organisations have elected to achieve the same goal by a different method, this has been made clear in the accompanying document.

14. It must now be the **core aim of the NHS and of organisations concerned with adult social care to ensure that safety and quality become the primary focus of all action and decision-making in each and every health and care setting**. In the words of Robert Francis, this response forms part of *'a journey towards a healthier culture in the NHS in which good practice in one place is not considered to be a reason for ignoring poor practice somewhere else; where personal responsibility is not thought to be satisfied by a belief that someone else is taking care of it; where protecting and serving patients is the conscious purpose of everything everyone thinks about day in day out'.* The measures we have put in place to date, along with the plans we have set out for future action mark the beginning of a profound change for the better in the culture of the NHS, a change that will improve both the outcomes and the experience of the people it serves. **No matter where patients and people using services choose to use a service, the over-riding concern must be that patients and service users receive the best possible care, from whichever provider they use, whether this is from the public, voluntary or private sector.**

15. *Patients First and Foremost* made it clear that the NHS and its staff did not need to wait for Government to act to make the aims of the Inquiry a reality. **Many in the NHS have met and exceeded our aspiration through the commitment and energy they have brought to making positive changes to put in place safe and compassionate care.** The Government and other national bodies will do all that they can to support their efforts in the months and years ahead.

Chapter 1 – Preventing problems

'We need common values, shared by all, putting patients and their safety first; we need a commitment by all to serve and protect patients and to support each other in that endeavour, and to make sure that the many committed and caring professionals in the NHS are empowered to root out any poor practice around them. These values need to be the principal message of the NHS constitution, to which all staff must commit themselves.'

Robert Francis QC

SUMMARY

In response to the Inquiry's report, we are taking steps to put patients first and drive safer care through creating open cultures that take effective action in response to staff and patient feedback. This will ensure that:

- The **values of the NHS Constitution** take priority, with putting patients first the overriding ethos of everything the NHS does (recommendation 4);
- All healthcare organisations and their staff are **honest, open and truthful** in all dealings with patients and the public (recommendation 173);
- It is easier to comment and make a **complaint** (recommendation 109);
- Each patient has an **identified senior clinician** in charge of their care (recommendation 236);
- There is a **culture of transparency** in the interests of patients and the public so that they are clear about the quality of care in their hospitals and on different wards (recommendation 2); and
- The National Institute for Health and Care Exce develops **evidence based tools on staff numbers and skill mix** (recommendation 23).

A compassionate and safe healthcare system depends on a 'conversation of equals' between patients and staff, strong unifying values, openness, and a learning culture that continually strives to reduce avoidable harm.

Since Robert Francis published his report:

- In a major breakthrough in NHS transparency, NHS England have for the first time published clinical outcomes by consultant for ten medical specialties (recommendation 2).
- The National Quality Board and the Chief Nursing Officer are publishing new guidance on safe staffing levels in hospitals and the National Institute for Health and Care Excellence has been commissioned to provide authoritative independent advice on evidence based tools to ensure the right levels of staff on every shift on every ward on every day in the NHS (recommendation 23).
- NHS England has also begun to publish data on the friends and family test (recommendations 246, 254, 255).

Key future actions highlighted in this chapter include:

- Every organisation registered with the Care Quality Commission will have to meet a new **duty of candour**. (Recommendations 2, 173-174, 180-181, 183-184)
- Health Education England is committed to introducing **values based recruitment** for all students entering NHS-funded clinical education programmes (Recommendations 2, 173, 185,188)
- Every hospital patient should have the **name above their bed** of the consultant and nurse responsible for their care. (Recommendations 199,236, 243)
- There should be a **named accountable clinician** for people receiving care outside hospital, starting with vulnerable older people (Recommendations 123, 238)
- By April 2015 every person with a long-term condition will be offered a personalised care plan. This will be agreed with their lead clinician. (Recommendations 238, 135)
- NHS England will create a **patient safety alert system** and publish data on 'never events' at first quarterly and then monthly. (Recommendations 41, 102)
- By Summer 2014, the National Institute for Health and Care Excellence will have produced guidance on **safe staffing** in acute settings, including a review and endorsement of existing staffing tools. (Recommendation 23)
- The Chief Inspector of Hospitals will monitor performance and take action where non-compliance puts patients at risk of harm. (Recommendations 2, 55-56, 64-65, 67-68, 78, 98, 101, 104, 118, 209, 221, 239-242).
- Development of the **patient insight dashboard** in a format that can be understood by patients (recommendation 2).

This chapter addresses themes and issues raised in the following chapters of the Inquiry's report: Chapter 1: Warning signs; Chapter 3: Complaints: process and support; Chapter 6: Patient and public local involvement and scrutiny; Chapter 20: Culture; Chapter 21: Values and Standards; Chapter 22: Openness, transparency and candour; and Chapter 26: Information.

A culture of high quality care

1.1 Preventing a repeat of the terrible events at Mid Staffordshire NHS Foundation Trust requires a culture of high quality care. This, in turn, depends upon getting the following right:

- Making a reality of compassionate, patient-centred care and making people partners in their own care;
- Building a culture committed to patient safety; and
- Supporting staff to care through staff wellbeing, values based recruitment and safe staffing.

People as partners – a conversation of equals

1.2 Most patients know less about the technical aspects of their condition and about how the institution delivering their care works than do the people treating them (although they are, of course, the experts on what it means and does to them). When this imbalance of power is not mitigated by person-centred care that emphasises the development of trust and partnership, and learns from feedback it can lead to terrible outcomes, as happened at Mid Staffordshire NHS Foundation Trust.

1.3 There is no single measure to correct this imbalance of power. A return to the paternalistic days of 'doctor (or nurse or care worker) knows best' is clearly as impossible as it is undesirable. Most of us are not patients or service users most of the time, and we are 'made' into patients or service users by the combination of what we bring to a care setting (including our needs and also our fears) and what the institution is like. There is a temptation to create processes which attempt to turn people into 'efficiently compliant' individuals. This can sometimes encourage people to accept poor care and poor behaviour.

1.4 When choice and control is extended to people, they will often seize it with enthusiasm, and shape services and outcomes positively. When people are given the chance to speak to the system about what they need and want, they provide invaluable insights for improving services. But much more needs to be done to involve people in their own care and therefore **statutory guidance for clinical commissioning groups on involving patients in planning services and in their own care has been published by NHS England along with a set of supportive tools[iii]. By December 2013, 80% of clinical commissioning groups will be commissioning support for patients' participation and decisions in relation to their own care or will have a plan to do so. This will include information and support for self-management, personalised care planning and shared decision-making.** It is also important to ensure that those patients who find active engagement with their care difficult or impossible are given the high-quality, compassionate support they need.

1.5 The Inquiry's report highlights the importance of compassionate care. *More Care, Less Pathway*, the report of the independent review of the Liverpool Care Pathway, has also identified instances of a lack of compassion in the care of the dying: *'Caring with compassion for people at the end of their lives should be the aim of all doctors, nurses and healthcare staff. Exceptional standards of care are required to look after people who may have co-morbidities, be in pain and frightened, and their distressed and anxious families.'* Effective compassionate care relies upon an understanding of the needs, wants and aspirations of

people in all their variety; and there is no better way of forming that understanding than getting to know someone as a person; and fewer times when this matters more than at the end of life.

1.6 **One of the lessons of both the Berwick and Keogh Reviews is that partnership with patients is the foundation for high quality care**: trying to solve safety problems as a series of business processes without working at understanding and forming partnerships with patients will not work. As part of the development of its new inspection methodology, the Care Quality Commission is holding a listening event for public and patients at the start of each inspection visit. This informs what Care Quality Commission inspects in testing its new methodology. In the longer term, Care Quality Commission has committed in its consultation document *A New Start* to speaking to more people who use services and frontline staff.

1.7 **From April 2013 it is a condition of Monitor's licence that Foundation Trusts actively engage with patients on the quality of care and take into account the views expressed. NHS England is also forming a Citizens Assembly that will put a citizen voice at the heart of decision-making and hold the board of NHS England to account, as well as working with patients and carers to develop a national 'Excellence in Participation Awards' scheme that gives status and profile to patient and public participation, and promotes best practice**.

1.8 The best and most compassionate services are rooted in a conversation of equals and sincerely ask of patients 'what could we do better' and 'what could we do to give you what you need'? This includes looking at how patients can be better supported to engage more effectively with services so that, for example, they know what to expect before going into a consultation and what they want from it; and that they feel confident in speaking up or querying if they feel something is not right. Involvement in the care planning process is particularly important for people with a long-term condition, including a long-term mental health condition. Therefore **by April 2015 every person with a long-term condition will be offered a personalised care plan. This will be agreed with their lead clinician**. People who are already receiving NHS Continuing Care will have a 'right to ask' for a personal health budget (including direct payments) from April 2014 and a 'right to have' one from October 2014. The new clinical commissioning groups will also be able to offer personal health budgets to others that they feel may benefit from the additional flexibility and control.

1.9 Since June 2013, all people in autism or learning disability hospitals have had a personal care plan**.** Our mental health strategy *No health without mental health* makes clear that care and **support for people with mental health challenges, wherever it takes place, should offer access to interventions and approaches that give people the greatest choice and control over their own lives**, in the least restrictive environment, and should ensure that people's human rights are protected.

A common language – the NHS Constitution

1.10 A conversation of equals requires a set of common values and expectations. The values, rights, pledges and responsibilities for patients and the public set out in the NHS Constitution provide a basis for this shared conversation and should be reflected in everything the NHS does.

NHS Values

Working together for patients. Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

Respect and dignity. We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

Commitment to quality of care. We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

Compassion. We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

Improving lives. We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

Everyone counts. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

A selection of the rights and pledges in the NHS Constitution

- **You have the right** to be treated with dignity and respect, in accordance with your human rights.
- **You have the right** to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.
- **You have the right** to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.
- **The NHS commits** to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice.
- **The NHS commits** to work in partnership with you, your family, carers and representatives.
- **The NHS commits** to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one.
- **The NHS commits** to encourage and welcome feedback on your health and care experiences and use this to improve services.

1.11 These rights and pledges, along with the values set out by the NHS Constitution, provide a framework for a new kind of conversation. Given the terrible failings in care at Mid Staffordshire NHS Foundation Trust and the appalling impact those failings had on the dignity and rights of the people under the Trust's care, it is important to emphasise the centrality of the principle, as set out above, that people are treated with dignity and respect. Taking such an approach means that rights (including consideration of relevant human rights) values and standards are explicit in policy, planning and delivery; as demonstrated by people participating in decisions which affect them, clear accountability, non-discrimination, empowerment of individuals, and application of legally enforceable rights.

1.12 It would be a fair challenge to ask why patients have not always experienced the rights and pledges set out in the NHS Constitution given that it has been in place for a number of years. It is true that, while there has been some progress in embedding the NHS Constitution since its launch in 2009, far more needs to be done to ensure it is, in Robert Francis' words, *'the first reference point for all NHS patients and staff'* and reinforces safe, compassionate care. That is why new legal duties were created, through the Health and Social Care Act 2012, on NHS England and clinical commissioning groups to promote the NHS Constitution, and a similar duty, through the Health Education England Directions 2013, was placed on Health Education England in its current form as a special health authority. In addition, subject to Parliamentary approval, the Care Bill will place Health Education England as an arm's length body under a duty to ensure education and training for healthcare workers is provided in such a way that promotes the NHS Constitution. NHS England, clinical commissioning groups, Health Education England and the Department of Health are working together with others, including NHS staff and patients, to develop **a joint strategy to comprehensively**

embed the NHS Constitution in everything the NHS does. The strategy will propose action in key areas, including: implementation of the Constitution's principles, values, rights and pledges in all organisations involved in delivering NHS-funded services; the role of leaders in championing Constitution values; and the importance of values to the recruitment, development and support of staff. Sustained improvement in how the NHS Constitution and its values are embedded across the country is most likely through a coordinated approach across the whole health system. The Department of Health is also committed to increasing the impact of the NHS Constitution so that patients and the public understand their rights and responsibilities and are clear about how to address concerns when they feel their care falls short. The Department is grateful to members of the Expert Advisory Group for their advice and suggestions on how this can be achieved.

1.13 An important connection for all providers to make to put in place the right condition for a conversation of equals is with **volunteers in health and care settings, who are often in a prime position to get to know people, and can have more 'space' to establish and maintain those closer relationships.** Practitioners can benefit from the unique perspectives and insights that volunteers often bring. Engaging local community groups and voluntary organisations in decision-making is also vital. Volunteers are often rooted in local communities and are a valuable source of knowledge and expertise that can help to deliver better personalised services to some of the most vulnerable people and communities in our society, including the elderly and those experiencing mental health challenges.

The Pod

'The people at The Pod asked me what they could do with me rather than for me. They talked with me rather than at me. I was able to build my self-confidence and skills, developing friendships which are fast and firm, rediscovering my faith in people.'

The Pod is a council resource for people determined to improve their mental health. It has completely transformed the way the day service is delivered and perceived.

There is no longer a 'day centre' ethos, where people go along to take part in scheduled activities. People are referred to the Pod to access one to one support to identify outcomes and to research and connect to opportunities. It advocates that people have capacity to direct and control their recovery journey. Utilising social brokerage expertise and optimising partnerships with universal services the staff secure personalised, innovative and sustainable outcomes with people.

Cultural change is sustained by a range of methods including coaching and mentoring and constant feedback from the people who use the services, the people that make referrals to the services and partner organisations.

For more information see: http://www.coventry.gov.uk/info/2000704/the_pod

1.14 As well as involving people in decisions about their own care, a key lesson of the Inquiry report is the importance of really involving and listening to patients wherever decisions about the shape and future of services are made. In part this is about user experience feedback driving service improvement informing the scrutiny of services. This will include:

- Use of **the friends and family tes**t as a catalyst for improvement activity within Trusts and the further rollout of the test to community and primary care. The friends and family test will be rolled out across mental health, community and primary care settings by the end of December 2014, and will cover all NHS services by the end of 2015.
- The Care Quality Commission through the Chief Inspectors of Hospitals, Social Care and General Practice **will use the insights of people who use services to guide and influence the inspection process** and the judgements that come out of it.
- The Care Quality Commission will work closely with **Healthwatch England** and **local Healthwatch** to ensure that inspection and ratings processes take account of the views of service users and the public. Healthwatch England and the Local Government Association recently launched **a tool to help local areas identify what outcomes and impacts a 'good' local Healthwatch could achieve**[iv]. It includes a menu of outcomes and impacts that can be adopted and adapted by local Healthwatch and council commissioners.
- **Monitor's assessment process also now includes review of patient surveys, meetings with patients groups, Healthwatch and asks about how boards engage with patients**
- **Complaints and concerns from patient groups and whistleblowers may also trigger regulatory action under Monitor's new Risk Assessment Framework introduced in October 2013.**
- **Patient experience** will be one of the key sources of intelligence for Quality Surveillance Groups.
- NHS England will publish **statutory guidance for clinical commissioning groups on involving patients in planning services and in their own care**.

1.15 Involvement also means engaging with service users and the public about the state of services and potential changes to them. This engagement needs to include staff as well.

Macmillan Values Based Standard®

Macmillan co-created the Macmillan Values Based Standard® with over 300 patients, staff, carers and families. This is a practical and innovative approach designed to improve both patient and staff experience, through facilitating the *diffusion of leadership to patients and front line staff*.

The Macmillan Values Based Standard® is based on eight behaviours that staff can use to demonstrate fundamental values such as dignity and respect towards patients on a daily basis. These behaviours reflect the things that patients and staff have said matter most to them: the things that patients expect staff to 'get right' and the things that staff want to 'get right' to feel that they have done a good job. Each behaviour has a patient, staff and leadership dimension which outlines what each need to do and the enabling conditions that need to be in place to ensure that these behaviours translate into practice.

The methodology underpinning the Macmillan Values Based Standard® involves patients and staff co-creating interventions to improve patient experience, ensuring that *patients are central to designing high quality, personalised care*.

Compassionate care

1.16 We all know compassion when we experience it. We all know when we are treated as a person rather than as a problem or a number. Compassion has to be something that happens between people for it to be real – you cannot be compassionate on your own – and compassion is more than empathy: it requires a commitment to act on behalf of somebody else.[v]

1.17 This means that there is a critical link between a conversation of equals and compassionate care. Many of the failures in compassion experienced by the patients of Mid Staffordshire NHS Foundation Trust were caused by or linked to failures in communication. Not listening to people is often the root of poor care. This is particularly important when the vulnerability of people using services makes it less easy for them to be understood by the people who are there to care for them. This applies to children, to people with communication difficulties, people with mental health problems, not least people in the last days and hours of life, but also to any of us who are fearful or anxious, as many of us are when we seek help from health and care services. Getting compassionate care right for those people whose vulnerability is compounded by, for instance, a learning disability or by the experience of abuse or sexual exploitation is particularly important, and something that all care providing organisations need to do more to understand and take action on.

#hellomynameis

During 2013 Dr Kate Granger, a senior registrar specialising in the care of older people, and who is also terminally ill, was an in-patient in NHS care and noticed that only some members of the healthcare team looking after her introduced themselves. Kate wondered why this fundamental element of good communication (the introduction) seemed to have failed. She noted how members of healthcare staff know so much about the patients in their care but that this is not always reciprocated and she pointed out that this tends to push the balance of power in favour of the healthcare worker. Given that people receiving treatment and care often feel vulnerable already, this imbalance creates an unhelpful and unfortunate gap.

Kate shared her views via twitter and suggested that getting to know people's names is the first rung on the ladder towards providing compassionate care. It is getting the simple things right that means that the more complex things follow more easily and naturally. As a result, the idea of #hellomynameis was born.

Since then people have taken steps in all manner of ways to ensure that this key bit of compassionate care; the introduction, happens. Some organisations have created name boards in their clinical areas headed 'Hello My Name Is…' and others have used it as they start their speeches at conferences and other events or placed it on name badges.

There is further work to do however. As Kate has pointed out, the NHS employs 1.4 million people and many, many of these people interact directly or indirectly with patients at some level. Influencing practice in this small way could have a major impact on the outcomes of care and treatment, not least of all around the patient's experience of that care.

1.18 Giving compassionate care may seem entirely reasonable to expect in a caring environment, but it can be incredibly hard work on the part of the individual providing the care. The emotional engagement and time required should not be underestimated[vi]. So if staff are to deliver good, compassionate care, it is critical to care for them so that they can care properly for others. Good working environments have the right levels of staff with the right skills, and support from colleagues and managers. Where staff are able to reflect on their practice individually and in teams, they can build on what works well and identify areas for improvement. Spaces for reflection and discussion such as Schwartz Rounds can help staff come to terms with the realities of caring.

1.19 Staff wellbeing is the foundation on which compassionate care must be built: it cannot be 'engineered in' through initiatives when this necessary condition does not apply. So, while compassionate care depends profoundly on the personal commitment of people providing the care, that does not mean that sole responsibility for achieving compassionate care should be placed on those who care directly for people using services, or imagine that it either 'comes naturally' or not at all. These themes are explored more fully in the Chief Nursing Officer's nursing strategy *Compassion in Practice*.

1.20 Systematically creating an environment in which compassionate care is the norm requires imaginative commissioning, organisational commitment, planning, education, training,

reinforcement through leadership and insightful scrutiny and challenge. It is the very opposite of the 'soft' issue it can too often be characterised as. Ensuring compassionate care is therefore not an 'issue' for organisations providing care. It is, along with safety, the essence of the business that they are in.

Ward observation tool: Sit and See

'*It was like having the lights turned on for me. I had become blind*.'

Nurses at Brighton and Sussex University Hospital NHS Trust asked themselves, what does delivering compassionate care actually look, sound and feel like for a person in hospital?

Working collaboratively with NHS Sussex and their Nurse Consultant for Safeguarding Adults, they developed an observational tool called *Sit and See*, together with a short training video. The tool enables staff to observe the small things which happen in everyday interactions with patients, which often make the biggest difference. It re-sensitises staff to the perspective of the patient, so easily lost in what for staff becomes routine care and has proved extremely powerful in inspiring staff to make improvements.

One ward sister talks of watching a housekeeper carrying out her duties in a very proficient way, pumping up a bed to clean under it, which is good for infection control. But the patient in the bed had dementia, and became distressed as the bed was raised because she did not understand what was happening. The sister realised that the housekeeper's knowledge of dementia was limited, and as a result, dementia training has been introduced for all housekeeping staff.

The power of information

1.21 Robert Francis stated that '*All professionals, individually and collectively, should be obliged to take part in the development, use and publication of more sophisticated measurements of the effectiveness of what they do, and of their compliance with fundamental standards*.' We agree.

1.22 Accurate, useful and timely information allows providers of services, their commissioners, regulators and others to identify early warnings to the quality of services and take immediate action to review and address them.

1.23 The Government and the NHS are committed to far greater transparency than in the past, and this will be driven through the wide availability of information. Over time data will become increasingly available to the public on the quality of services through Care Quality Commission's new inspection regime and by extending the information that is available through NHS Choices. NHS England will also improve data that is already published including by reviewing the use of Quality Accounts and making more information available at specialty level.

1.24 NHS England will publish the most useful data and insight through the **Patient Insight Dashboard** in a format that can be understood by patients, the public and local Healthwatch, in Autumn 2013.

1.25 Where such data is made transparent it also supports choice for people who use services and promotes the sharing of information to those who need it to improve quality. However, the usefulness of data needs to be carefully balanced with the burden of its collection and the collectors and commissioners of data requests need to work with the Health and Social Care Information Centre to reduce unnecessary burden and release time to care.

1.26 Information technology can support reducing the burden of data collection and can be a powerful means of supporting an equal conversation between those who provide and use services. **By spring 2015 every patient will be able to see their records, test results, book appointments and order repeat prescriptions online. They will also be able to communicate with their GP practice electronically.** This will support a greater transparency for patients about their care and treatment and make it easier for patients to access details about their care and its outcome.

1.27 In its response to the Caldicott Review, *Information: To Share or Not to Share*, the Department of Health stated that health and care professionals must decide how information is shared in the best interests of people and patients. The new Health and Social Care Information Centre guidance, *Guide to Confidentiality in Health and Social Care* states that, *'Individuals need the teams of professionals who are responsible for their care to share information reliably and effectively … in order to provide a seamless, integrated service.'*

1.28 The Health and Social Care Act 2012 requires the Health and Social Care Information Centre to establish and operate a system for the collection or analysis of information in connection with the provision of health services and adult social care in England. Its work includes the publication of more than 130 statistical publications annually; providing a range of specialist data services; managing informatics projects and programmes and developing and assuring national systems against appropriate contractual, clinical safety and information standards.

1.29 The Informatics Services Commissioning Group, established in 2013, has been set up to **enable the Health and Social Care Information Centre to become the focal point for data collected at the national level; and it will increasingly act as a 'gateway' for those seeking new data collections, with a clear remit to reduce burdens and co-ordinate the collection of information more effectively.**

The responsibilities of patients and the public

1.30 If NHS organisations are sincerely and courageously open to engagement and dialogue with patients and the public about their own care but also more strategic questions, the public will respond positively. Don Berwick's report includes a set of 'actions for patients and carers' which provide some guidance on what this sort of engagement might mean from a patient perspective. This builds on the responsibilities set out in the NHS Constitution. While the responsibility to start the conversation with the people they serve rests primarily with NHS organisations, the future of that conversation also depends on the active engagement and involvement of patients, carers and the public.

A strong voice for patients – Healthwatch

1.31 If patients and the public are to become full partners in their own care, their views must be heard on a range of issues. That is why the Government has put in place a system of national and local Healthwatch to act as a champion for people using services across health and social care. Local Healthwatch organisations have now been commissioned by every local authority. Based in local communities, they will gather views from across the board (and not just from those who shout the loudest) to highlight how services in health, public health and social care should improve. Local Healthwatch contact details can be found on the Healthwatch website.

1.32 The Government has been working with partners to ensure organisations such as local Healthwatch and scrutiny committees are in the best possible position to root out examples of poor care, rather than become preoccupied with form and procedure. We accept Robert Francis's argument that *'the complexities of the health service are such that proper training must be available to the leadership of Local Healthwatch as well as, when the occasion arises, expert advice'*[viii]. **Guidance has been created to support effective scrutiny in local authorities, and training has been given to local Healthwatch organisations across the country to ensure that they can maximise the impact of their power to enter and view local services**.

1.33 **Local Healthwatch organisations are using their 'enter and view' powers to get a clear picture of how health and care services are meeting the needs of the public**, and their place on every local health and wellbeing board will ensure that voices of people using services is at the heart of local planning and decision-making.

1.34 Local Healthwatch will also enhance the new inspection regimes. They will **make sure inspection teams get a comprehensive picture of local people's opinions and concerns**, and will maintain a focus on service quality issues after the inspection team has moved on.

NHS Kernow and Cornwall Partnership NHS Foundation Trust: Improving children's access to a diagnostic service for autistic spectrum conditions

After discovering that a high number of children aged 5 and over who were not presenting with a mental health issue were not getting the diagnostic they wanted, NHS Kernow and Healthwatch Cornwall have worked together to take action to ensure that this is addressed.

After gathering robust evidence about what was happening on the ground, solid data was presented to local commissioners and the health and social care scrutiny committee to show that there was a major gap in the services. This gap was causing distress to a number of families.

As a result of Healthwatch Cornwall highlighting the gap, a long-term resolution has been in place since the beginning of October which reflects NHS best practice clinical guidelines.

Listening to complaints, and acting on them

1.35 A genuine conversation of equals would place a premium on understanding and making improvements in services in response to complaints. Complaints often contain hard truths, but, looked at in the right way, they can provide tremendously valuable nuggets of insight and be the source of improvements in patient care. A number of NHS organisations have shown how to use complaints effectively as a catalyst for improvement and as a warning light in relation to poor practice. The review led by Rt Hon Ann Clwyd MP and Professor Tricia Hart concluded that:

- Vulnerable people find the complaints system complicated and hard to navigate
- There is a low level of public awareness of the NHS Complaints Advocacy Service
- People are reluctant to complain and staff can be defensive and reluctant to listen to or address concerns
- Organisations do not always deliver their legislative responsibilities on complaints handling
- There is a need for quality, trained staff to deal with complaints effectively and appropriately.

1.36 The key recommendations included:

- Every Chief Executive should take personal responsibility for the complaints procedure.
- There should be Board-led scrutiny of complaints.
- There should be a new duty on all Trusts to publicise an annual complaints' report, in plain English, which should state what complaints have been made and what changes have taken place.
- Trusts should provide patients with a way of feeding back comments and concerns about their care on the ward including simple steps such as putting pen and paper by the bedside and making sure patients know who to speak to if they have a concern – it could be a nurse or a doctor, or a volunteer on the ward to help people.
- Patient and advice liaison services should be re-branded and reviewed so it is clearer what the service offers to patients and it should be adequately resourced in every hospital.
- The Care Quality Commission should include complaints in their hospital inspection process and analyse evidence about what the Trust has done to learn from their mistakes.
- Trusts should actively encourage both positive and negative feedback about their services.

1.37 The Government welcomes and accepts the spirit of the review and the principles behind the recommendations, although many are for action at individual Trust level. The key changes the Government wants to see include:

- Trust Chief Executives and Boards should **promote a culture of openness** and encourage feedback and welcome complaints. Staff must be trained and encouraged to seek feedback, and act on it.
- The Government wants to see every Trust make clear to every patient from their first encounter with the hospital:

  - how they can complain to the hospital when things go wrong;
  - who they can turn to for independent local support if they want and where to contact them;
  - that they retain the right to complain to the Ombudsman if they remain dissatisfied and how to contact them; and
  - details of how to contact their local Healthwatch.
- A sign in every ward and clinical setting would be a simple means of achieving this and the Department will be discussing with Healthwatch England, Care Quality Commission and NHS England the best means of ensuring this becomes standard practice in all NHS hospitals in England. We would expect these posters to set out how to complain about a hospital, how to seek support from their local Healthwatch and how to refer their complaint to the Ombudsman.
- It is important that local Healthwatch, as the patient and public champion for health and care services, should be as strong and effective as possible so that it can speak up for patients and provided independent support on complaints, a role that is also open to other providers.
- **We want to see Trust Chief Executives and Boards taking personal responsibility for complaints handling**. This includes signing off letters to patients, ensuring every patient is offered a conversation at the start of the complaints process, and that they are clear that if they are not happy with the way the complaint has been handled they can get an independent view from the Health Service Ombudsman.
- **We want to see Chief Executives ensuring there is greater clinical involvement in handling complaints**. This could be through offering patients a conversation with the nurse or doctor involved in the complaint, if that is something the patient wants.
- **We also want to see Directors with responsibility for patient safety being required to give an update on complaints at each Board meeting** and we will work with NHS England to determine the most effective mechanism through which to achieve this.
- **We want Boards to see regular data about complaints which means** the 'narrative and not just the numbers', so they can identify themes and recurring problems, and take action. All Trusts, not just the good ones, should see complaints as an opportunity to learn and improve the care they provide.
- **Detailed information on complaints and the lessons learned will be published quarterly.** This will include the number of complaints received as a percentage of patient interventions; the number of complaints the hospital has been informed have subsequently been referred to the Ombudsman and the lessons learned and improvements made as a result of complaints.
- The Government will explore with NHS England and other key partners the introduction of **a regular and standard way of surveying people who have made a complaint** to find out whether they were satisfied with the way it was handled, and to enable comparison across hospitals.

- We will work with the Health and Social Care Information Centre to put complaints data into the existing NHS electronic data collection system, better enabling comparison between hospitals.
- We agree it is appropriate to review the patient and advice liaison services service, and will undertake to begin that review in 2014.
- We agree that there is an important role for local Healthwatch to play in scrutinising complaints, and complaints handling locally. **We want to see local HealthWatch scrutinising complaints data across Trusts in an area to spot themes** and recurring issues in an area with their unique local perspective. Whilst it is important that Trusts respect patient confidentiality when releasing information on complaints to outside organisations but, subject to this caveat, we strongly consider that Trusts should seek to provide the complaints data that are requested by local Healthwatch and Overview and Scrutiny Committees.
- The Department agrees that complaints should be a key part of the **new Chief Inspector of Hospital's inspections and welcomes this commitment.** The Chief Inspector will look at how well a Trust deals with complaints and this will involve looking at a sample of real life complaints and what action was taken, as well as talking to patients.
- **The Department of Health will work with Action against Medical Accidents and NHS England to clarify that a threat of future litigation should not delay the handling of a complaint.**
- The Parliamentary and Health Service Ombudsman is independent of the NHS and Government, and provides an important service to patients, giving them somewhere to turn if they feel their complaint is not handled properly locally. **The Department welcomes the Ombudsman's ambition to increase significantly the number of cases she takes on**, and her valuable role helping the health system to interrogate and learn lessons from complaints.
- The Government has asked the Parliamentary and Health Service Ombudsman and Healthwatch England, working with the Department of Health, to develop a patient-led vision and expectations for complaints handling in the NHS. The Parliamentary and Health Service Ombudsman, Healthwatch England and the Department of Health will work with the Patients Association, patients, regulators, commissioners and providers to develop universal expectations for complaints handling. These will be used across the NHS to drive improvements in patient satisfaction with complaint handling. The vision and expectations will inform:
  - Patients about what to expect when they make a complaint about NHS services
  - The work of the Healthwatch network in challenging local providers to improve their practices
  - Providers and commissioning bodies about what they can do to use patient concerns and complaints to improve services and how they can measure their own progress
  - Regulatory assessment of hospital complaint handling

  - The Parliamentary and Health Service Ombudsman investigation of complaints about NHS services brought to them by patients and their families.
- The Parliamentary and Health Service Ombudsman is working with the Care Quality Commission on what insight she can provide on complaints she has investigated to inform hospital inspections.

1.38 For further detail, see Annex D to this report.

Royal United Hospital, Bath

Staff and management at the Royal United Hospital, Bath, know that by listening to feedback and being open to making changes, they can improve their patient services. Both during and after their time in the hospital, patients and relatives have many options for commenting on their experiences besides using the traditional patient and advice liaison services and Complaints routes. For instance, patients and relatives who want to give more immediate feedback are invited to meet for a cup of tea with the ward sister on a weekly basis on the wards. Other methods of feedback include the friends and family test at the point of discharge. Patients and carers can also use the in-house real-time patient feedback system, which can also be accessed on line from the patient/carer's own computer.

One of the ways that the Royal United Hospital works with patients, families, carers and staff is by presenting their stories at *'See it my way'* events. Patient focused events such as these allow staff to reflect on the hospital experience from the patients perspective and staff agree from the feedback collected after these events, that it provides real value in terms of their overall understanding of how patients and their families lives are affected due to specific conditions and how they can adapt their own working practices to benefit patients in future.

Safe care for patients

1.39 A deep and broad commitment to patient safety is one of the key preventive measures for ensuring that a tragedy of the kind that occurred at Mid Staffordshire NHS Foundation Trust does not recur. Patients and users of services should expect that their safety is the paramount concern of those who care for them. The events at Mid Staffordshire set out in Chapter 1 of the Inquiry's report reveal a Trust that failed to give patient safety the highest priority. While you cannot eradicate harm because the complexity of modern medicine makes that impossible, there should be no room for its tolerance.

1.40 The Government asked Professor Don Berwick to lead a review into the safety of patients. The subsequent report, *A promise to learn – a commitment to act*[ix] delivered by the National Advisory Group for Patient Safety tells us that there needs to be a balance between a learning culture that is open and, when mistakes are made, free from an unjustifiable urge to blame and seeks to improve and as far as possible ensures that the small number of people in the NHS who cause harm due to neglect or wilful misconduct are identified, removed and, where appropriate, held to account for what they have done. The changes being introduced

will be based on the principle that a patient safety culture should be both just and committed to improvement.

1.41 **We will act to tackle wilful neglect.** The Government agrees with Professor Don Berwick's recommendation that there should be a new criminal offence *'in the very rare cases where individuals or organisations are unequivocally guilty of* ***wilful or reckless neglect*** *or mistreatment of patients'.* This will help to ensure that there is ultimate accountability for those guilty of the most extreme types of poor care. The Government will seek to legislate on this, and will work with stakeholders beforehand to determine the details of this measure, and will consult on proposals for legislation as soon as possible.

Onion – Peeling back the layers, putting patients first at Watford, St Albans and Hemel Hempstead Hospitals

'Onion' asks, 'What can we do today to make a difference to our patients?' The West Hertfordshire NHS Trust gather together every day as a multi-disciplinary team with staff from across its hospitals and partner organisations, including doctors, nurses, midwives, managers, administrators and others, with regular attendance from social care, the local ambulance service and clinical commissioning group.

It therefore brings together a wide and challenging range of skills, disciplines, opinions and, critically, solutions. Onion is open to all and every day the discussion is new and varied, but always open, honest and usually emotive – staff talk about their patients, their failings and their successes.

Reinforcing patient safety is the number one priority. Onion is going back to basics and is about making everything possible and finding the solutions rather than accepting the status quo. No issue is too small – from pigeons to portering to pathology labels to palliative care to senior doctor cover.

'Onion' involves basic questions, listening and acting:

- Are there any issues of patient safety; patient experience or staffing?
- Listening, peeling back to the root cause; and being prepared to change it;
- Seeking evidence and positive assurance.

Within two days, word-on-the-ward was: ''Onion' has sorted something in three days that I haven't been able to sort in a year.'

The Onion's measure of success is patient experience and safety. 'Onion' has cost little to initiate other than courage, time and commitment from many people, not least the senior leaders.

A learning and improvement culture

1.42 The report of Don Berwick's National Advisory Group on the Safety of Patients in England stated that *'The most important single change in the NHS in response to this report*

would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.' We agree.

1.43 **NHS England are working with NHS Improving Quality to develop proposals for the establishment of a network of Patient Safety Collaboratives across England**. The aim of the Collaboratives is to create a comprehensive, effective, and sustainable improvement system that will deliver a culture of continual learning and improvement in patient safety across the country over the next five years. The Collaboratives will engage with local providers and experts in patient safety and improvement to design an innovative approach to large scale change, and build on existing national and regional initiatives in patient safety, as well as improvement collaboratives that have had an impact in other clinical areas, notably in cancer, heart disease and stroke.

1.44 The Patient Safety Collaboratives will:

- offer the opportunity for people to work together locally to address and improve patient safety in their own settings,
- build skills and capabilities in patient safety and improvement science,
- use evidence based improvement methodologies,
- include primary, community, mental health, acute or other sectors, and focus on the actions that can make the biggest difference to their patients.

1.45 Participating organisations will, in part, set their own priorities and devise their own solutions, within an overall framework of support from national experts in patient safety, improvement science and large scale change. Building on the experience of previous improvement programmes there will be a focus on measurement from the outset to ensure that organisations are able to track safety incidents over time as well as testing some innovative measures of safety culture and teams. There will also be investment in and commitment from leaders at all levels of the organisation including Board level sponsorship. Finally, evaluation will be built in from the outset to ensure that we establish what changes are effective and the overall effectiveness of the Patient Safety Collaboratives.

1.46 NHS England and NHS Improvement Quality will seek to finalise the design of the Collaboratives, put in place the support and development capacity and recruit participating organisations by spring 2014.

1.47 The programme will include establishing a **Patient Safety Improvement Fellowship** scheme to develop 5,000 Fellows within a national faculty within five years.

Patient safety culture

1.48 The lessons from the Public Inquiry and reiterated in the reviews led by Professor Don Berwick and Sir Bruce Keogh show that safe care is dependent on healthy cultures: having the right values, behaviours and optimum systems and conditions to minimise harm and to learn from patient safety incidents. Professor Michael West's recent study on the culture and behaviour in the NHS[x] describes these conditions and how they can generate either 'bright spots' or 'dark spots' in care.

Culture and behaviour in the English National Health Service from the blunt end to the sharp end: findings from a large multi-method study, Dixon-Woods et al, BMJ 2013

The Department of Health commissioned a large research programme to examine culture and behaviour in the NHS in England. The research team found an almost universal desire to provide the best quality of care. But despite evidence of 'bright spots', realising this aspiration was challenged by unclear goals, overlapping priorities that distracted attention, and compliance-oriented bureaucratised management. Some organisations found it difficult to obtain valid insights into the quality of the care they provided. Poor organisational and information systems could leave staff struggling to deliver care effectively and disempowered from initiating improvement. Good staff support and management were fundamental to culture and were directly related to patient experience, safety and quality of care but were also highly variable.

The results highlight the importance of organisational missions that emphasise both values and goals related to high-quality care, of outstanding people management that ensures staff feel valued, respected, engaged and supported, judicious use of intelligence, of improving organisational systems, and nurturing caring cultures. These components are mutually reinforcing; it is difficult to realise high-quality patient care if any aspect is defective.

1.49 All staff must have a constant and active awareness of the potential for things to go wrong and the ability and confidence to then put things right. It is vital that all healthcare professionals receive education and support on the principles and practices of patient safety including the measurement of quality and patient safety and the skills for engaging patients actively. **Health Education England will ensure that there is an increased focus on delivering safe, dignified and compassionate care on the education and training of professionally qualified healthcare and public health staff.**

1.50 Patients and the public need easy access to reliable and accurate information about the safety of their hospital. **The Care Quality Commission and NHS England will develop a dedicated hospital safety website for the public which will draw together up to date information on all the factors, for which robust data is available, that impact on the safety of care.** This will include information on staffing, pressure ulcers, healthcare associated infections and other key indicators, where appropriate at ward level. The website will aim to begin publication from June 2014. This will over time become a key source of public information, putting the truth about care at the fingertips of patients.

1.51 The National Quality Board recognises that much of the activity to embed Human Factors in healthcare sits with frontline providers and commits to working with NHS organisations, clinicians and NHS staff to understand their current capabilities, establish their requirements and develop a work programme of tailored support that enables NHS organisations to maximise the potential that Human Factors practices and principles can offer in relation to patient safety, efficiency and effectiveness. NHS England and Health Education England will lead the work to support the NHS in taking forward this important aspect of

the patient safety agenda. The National Quality Board is publishing a 'Human Factors in Healthcare Concordat' signed by its member organisations.

1.52 Patient Safety Alerts are a key way to help providers reduce the risks inherent in the care they provide. **NHS England will therefore re-launch the patient safety alerts system by the end of 2013 in a clearer framework that will support organisations to understand and take rapid action in relation to patient safety risks.** This new system will include greater clarity about how organisations can assess their compliance with alerts and other notifications and ensure they are appropriately implemented**.**

Transparency and measurement

1.53 When a patient enters a hospital ward, they want to know that safe care is the first priority. Trusts will continue to be encouraged to use the **NHS Safety Thermometer to help drive improvements in some key patient safety areas: pressure ulcers, falls resulting from harm, catheter-associated infections and venous thromboembolism.** There will be a particular emphasis on pressure ulcers and NHS England will work with health care providers to reduce the incidence of pressure ulcers. We also want to improve the accessibility of this data and the data on patient safety more generally. There are already huge volumes of data available, for example NHS Safety Thermometer data is already published down to individual ward level. But patient safety data is not simple. It usually paints a complex and contradictory picture that is difficult to interpret for professionals and patients alike. NHS England will therefore work with Care Quality Commission, Monitor, NHS Trust Development Authority, the Health and Social Care Information Centre and others to make patient safety data more accessible to all and provide clear guidance on what it means – and does not mean.

1.54 Specifically, the Care Quality Commission and NHS England are already establishing a shared understanding of patient safety data to ensure that any information used to assess patient safety – from no matter what source or for what purpose – is analysed and presented in a robust and accurate way. This will mean that trusts are clear on what patient safety data means and how it will be used by regulators and commissioners, and they will be encouraged to ensure that such information is available to their patients.

1.55 NHS England will begin to **publish never events data quarterly before the end of 2013, and then monthly by April 2014** to help Trusts, patients and the public drive improvement of services.

1.56 Openness and transparency are important and necessary if patients and the public are going to trust that every effort is being made to make health and care as safe as it possibly can be. In a major breakthrough in transparency, **NHS England have for the first time published clinical outcomes by consultant for ten medical specialties.** There is a greater commitment now to put a spotlight on how the NHS is improving on safety and use what is agreed to be the best available data. There is also the aim to make the use of the safety information more consistent so that it can help support monitoring as well as inspection and reviews by professional and health and care regulators.

1.57 **NHS England is leading work to develop proposals for ensuring every trust undertakes retrospective case note reviews of patient deaths according to a consistent**

methodology to further encourage learning from adverse events. This will help trusts address common issues associated with avoidable hospital mortality, such as management of deteriorating patients and NHS England is exploring how this can be used to support the development of a national measure of avoidable deaths.

Openness and candour

1.58 *Patients First and Foremost* included a proposal for a new duty of candour, as a requirement for providers registered with the Care Quality Commission. As from 2014 every health and adult social care provider will be required to meet this duty. **As a mark of the Government's commitment to the duty of candour, the Care Bill puts a requirement on the Secretary of State to include a duty of candour in the requirements for registration with the Care Quality Commission.** It is already a requirement of Monitor's licence that information provided is accurate, complete and not misleading and licence holders are expected to notify Monitor in the event of any incident, event or report that may raise concerns over compliance with their licence.

1.59 It is vital that **whistleblowing** is taken seriously; in legislation, inspection and education and training. In addition, in April 2013, the Enterprise and Regulatory Reform Act 2013 strengthened the position of whistle blowers so that an individual now has the right to expect their employer to take reasonable steps to prevent them suffering detriment from a co-worker as a result of blowing the whistle.

1.60 As the regulator of health and care Care Quality Commission is using staff surveys and the whistleblowing concerns it receives as part of the data in its new intelligent monitoring system. This data will guide Care Quality Commission about which hospitals to inspect. Since September 2013 Care Quality Commission's new inspection system includes discussions with hospitals about how they deal with whistleblowers.

1.61 The duty of candour is a further drive towards openness and transparency. We have set out in the Care Bill we intend that in future, as a registration requirement with the Care Quality Commission, providers must be open with patients about care failings. The duty should drive an open culture throughout organisations, including its staff, so we do not believe an individual obstruction offence is necessary at this time.

1.62 In addition to candour at the organisational level, it is vital to ensure that individuals live up to their professional obligations to be candid. We are working with the professional regulators to strengthen the references to candour in professional regulation. The professional values of individual clinicians are critical in ensuring an open culture in which mistakes are reported, whether or not they cause actual harm. **The General Medical Council, Nursing and Midwifery Council and the other professional regulators will be working to agree consistent approaches to candour and reporting of errors, including a common responsibility across doctors and nurses, and other health professions to be candid with patients when mistakes occur whether serious or not, and clear guidance that professionals who seek to obstruct others in raising concerns or being candid would be in breach of their professional responsibilities**. We will ask the Professional Standards Authority to advise and report on progress with this work. **The professional regulators will develop new guidance to make it clear professionals' responsibility to report 'near misses' for errors that could have led to death or serious injury, as well as actual harm,**

at the earliest available opportunity and will review their professional codes of conduct to bring them into line with this guidance.

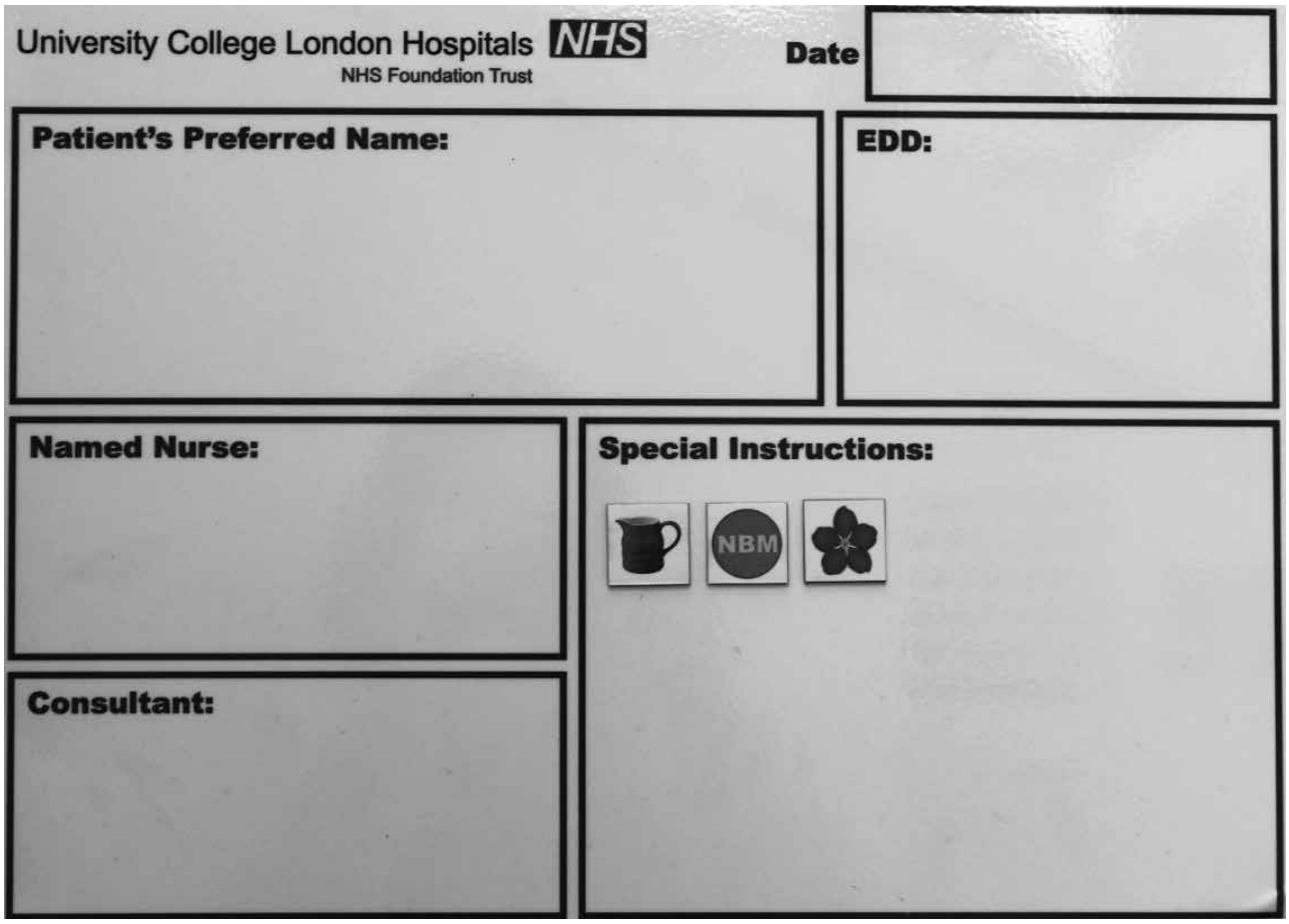
1.63 There are various views on the threshold at which the duty of candour should be set: not so narrowly that important incidents are excluded, nor so broad that defensive behaviour and excessive bureaucracy grow to excess. **We do accept Professor Don Berwick's recommendation that we should avoid an automatic duty of candour where patients are told of every error or near miss.** There is also a range of views on extending the threshold for the duty of candour to cover moderate harm as well as death or serious injury. **The Government has therefore asked David Dalton, Chief Executive of Salford Royal NHS Foundation Trust and Professor Norman Williams, President of the Royal College of Surgeons, to assess these arguments along with the practical implications involved in such a threshold by the end of the year.** The Department will consult on a draft set of regulations, which also provides the flexibility to be amended or varied over time as the new duty is established.

1.64 The Government will consult on proposals about whether Trusts should reimburse a proportion or all of the NHS Litigation Authority's compensation costs when they have not been open about a safety incident. Where the NHS Litigation Authority finds that a Trust has not been open with patients or their families about a patient safety incident which turns into a claim, it could have the discretion to reduce or remove that Trust's indemnity cover for that claim. The NHS Litigation Authority will continue to make compensation payments due to patients. Trusts who were not open with their patients could be required to reimburse the NHS Litigation Authority for a proportion or all of the payment.

Safe care for each and every patient: the role of the named clinician

1.65 Safety is personal: it is not simply a matter of checklists and processes. Getting to know patients and managing their journey through the system effectively can make all the difference in ensuring they are cared for safely**. Every patient should therefore have a named consultant who is responsible for their care while they are in hospital.** The role of the named consultant will be to be responsible for the patient's safety concerns at every stage of treatment and will ensure that the patient's care and medical treatment is planned and delivered around the patient's needs.

1.66 In his speech on patient safety on 21 June 2013, the Secretary of State for Health signalled his support for the practice of hospitals identifying a **named consultant** who is responsible for a patient's care. This happens in a number of Trusts already – University College London Hospitals NHS Foundation Trust and Kings College Hospital in London have agreed to introduce it and the Department would encourage other organisations to do so including mental health providers.



The 'named clinician' board used by University College London Hospitals.

1.67 At a seminar hosted by the Academy of Medical Royal Colleges on 25 September 2013, it was clear there was a strong professional consensus around this and the Academy is leading work to take it forward. The Academy will produce key principles with worked examples on how this can be implemented in a way that sustains professional support.

1.68 The Government is also proposing the introduction of a **named accountable clinician for people receiving care outside hospitals, starting with vulnerable older people**. The Government proposes that the most vulnerable elderly would benefit from having someone in primary care taking responsibility for ensuring that their care is coordinated and proactively managed. Just as patients in hospitals should be under the care of a named consultant, we need to ensure that when a vulnerable older person needs follow-up or on-going support having left hospital, that somebody is accountable for their care. Although this clinician may not provide the care directly themselves, they would be the person with whom the buck stops and would be an identifiable point of contact for a patient or their family.

1.69 The Government has been testing its proposals over the summer through engagement with patients, carers, health and social care staff, and will be setting out its plan for improving out-of-hospital care for vulnerable older people later in the year. This has been reflected in the refreshed Mandate to NHS England for 2014–15.

Supporting staff to care

Staff wellbeing and improved care outcomes

1.70 There is strong evidence that where staff are well supported and where their well-being is a priority for their organisation, there is a significant and positive impact on outcomes for patients and service users.[xi]

1.71 Supporting staff wellbeing means recognising the impact of the work that they do. The pioneering work on Schwartz rounds is one example of how staff can be supported to deal with the realities of care for staff. The Government has already signalled its support for this work. In May 2013, **the Department announced a £650,000 grant to the Point of Care Foundation, to expand their work on piloting Schwartz Rounds in NHS hospitals.** Schwartz Rounds allow NHS staff to get together once a month to reflect on the stresses and dilemmas that they have faced while caring for patients. Robert Francis specifically pointed to the positive impact of Schwartz Center Rounds in his report. Monthly Schwartz Center Rounds are currently established in 15 NHS trusts and are operating in a number of different health care settings, including a prison, HMP Swinfell Hall. By the end of the two years of the grant, around 40 additional Trusts should have established Schwartz Center Rounds. The Point of Care Foundation will also have developed a national network of trainers and mentors who will continue to spread Schwartz Center Rounds to new organisations into the future. For the first time ever, they will also be piloted with GP practices, district nurses and in the community.

1.72 The Department has also commissioned a **programme of work from NHS Employers to provide support and resources to NHS trusts to better support the emotional well-being and engagement of their staff.** This work will include interventions at both line manager and Board level in individual Trusts, to promote better identification and improvement of staff wellbeing and engagement.

1.73 The efforts of providers to improve the experience of staff need to be reinforced by commissioners and national organisations:

- NHS England have therefore affirmed their commitment to staff experience in their Business Plan, *Putting Patients First*, which lists '**Motivated, positive NHS staff'** as one of the key indicators against which their success will be measured in the coming years.
- Compassion in Practice, the nursing vision for England, has an action area around **supporting a positive staff experience, and nurturing a culture of compassionate care**.
- This includes supporting the on-going work to develop and test a **Cultural Barometer** in a small number of London Trusts, which aims to help managers, leaders and staff at the point of care to reflect on the culture of their organisation, department or team or, indeed, themselves.
- The Compassion in Practice team will also work with the social care sector to determine how the 6Cs can support leaders and their staff in improving care locally.

Values based recruitment

1.74 The Inquiry report highlighted the critical role played by the workforce in ensuring the provision of high quality and safe healthcare services and, in particular, the significance of staff values and behaviours to the care experience.

1.75 'Values' may seem a rather abstract concept to some, miles away from the daily realities of health and care services. The truth is, however, that the values a person holds are manifested through their attitudes and behaviour, and that the connection between values and leadership is critical to the success of health and care organisations. There is good evidence that the values articulated and modelled in behaviour by leaders at all levels of an organisation have a strong influence on the values of the people who work in that organisation.

1.76 Recruiting for values plays an important role both in selecting the right people for the job and in reinforcing to the organisation as a whole what really matters. It is therefore vital that the staff of tomorrow are able to demonstrate not only academic and technical ability, but also that they have the values of kindness and compassion that are needed to care for patients in an emotionally demanding environment. Health Education England and Local Education and Training Boards, working with employers and education providers, are responsible for the development of the future workforce and also have a role to play to ensure that the current workforce is fit for purpose and able to provide care of the highest quality. As set out in its mandate, **Health Education England is committed to the introduction of Values Based Recruitment for all students entering NHS-funded clinical education programmes, using the values set out in the NHS Constitution,** and to support such processes for recruitment into NHS employment.

Values Based Recruitment

The three key objectives of Health Education England's national Values Based Recruitment programme focus on:

- Recruiting for Values in Higher Education Institutions;
- Recruiting for Values in the NHS; and
- Evaluating the impact of Recruiting for Values.

Over the long term, Health Education England will develop value-based recruitment as part of a wider programme to change attitudes and behaviours of NHS staff, enhancing their engagement and continuously improving healthcare for its patients.

King's College London: Using children to help recruit children's nurses

This innovative project set out to include service users in the recruitment and selection of children's nursing students to the BSc and PGDip programmes with registration as a children's nurse. The project also addressed the role of the School of Nursing and Midwifery in widening participation and community engagement.

The project incorporates the views of children and young people into both the initial shortlisting of candidates and the design of the group task that candidates are asked to undertake on the selection day.

Six focus groups were held in schools that involved children aged from nine to 16 years. The format involved the children and young people identifying what the attributes of a children's nurse should be and then commenting on the group task. The responses to the discussion at the focus groups have been analysed to identify common themes and these will be used to refine the shortlisting criteria used in particular when looking at personal statements and to refine the scoring sheet used for the group task undertaken at selection days.

Ensuring safe staffing

1.77 Staffing levels are critically important. Too often as Sir Bruce Keogh found, insufficient staffing levels are a contributor to poor care. The Care Quality Commission's new inspection regime, led by the Chief Inspector of Hospitals, Sir Mike Richards, will look explicitly at staffing levels. Patient safety depends in part on the wise use of resources. Getting the right staff in place so that patients' needs are met to a high standard of quality without leaving staff overstretched and tired to the point where they find it difficult to care compassionately is one of the key responsibilities of leaders throughout the system. This will become ever more challenging as we move into a context of increasing demand from an ageing population on limited resources, and as further advances in medicine make new treatments possible. Providers, commissioners, regulators, educators and government all have a responsibility to help ensure safe staffing.

1.78 The Boards and leaders of providers need to have a detailed understanding of the workforce in their organisations. This means having systems and processes in place to provide assurance that the right number of staff are in place, at the right time. This goes far beyond simply looking at regular workforce reports and checking that the right number of staff are in place overall. As Sir Bruce Keogh's review showed, staffing levels can vary greatly shift to shift and ward to ward[xii]. Boards need to both understand the realities of staffing in their organisations and to be able to set that against the best available evidence based guidance.

1.79 It is imperative that healthcare organisations are supported by independent, well-evidenced, clear and authoritative guidance to ensure that they are able to provide the right numbers and mix of staff to meet the needs of patients and service users. To this end, the Chief Nursing Officer has led the development of staffing guidance and, as a result, the **National Quality Board and the Chief Nursing Officer are publishing a guidance**

document that sets out the current evidence on safe staffing and includes a set of expectations for NHS organisations. This document sets out the current shared understanding of key national NHS organisations of what the current evidence means for decisions about staffing.

1.80 More needs to be done to build on this guidance, and the Department of Health has therefore asked National Institute for Health and Care Excellence to set out **authoritative, evidence based guidance on safe staffing. By Summer 2014, National Institute for Health and Care Excellence will have produced guidance on safe staffing in acute settings, including a review and endorsement of existing staffing tools.** This initial phase will be followed by further work to develop **similar tools and endorsement in non-acute settings, including mental health, community services and learning disability.** The focus of the work will be nursing and maternity staffing levels, but it will also take into account the importance of getting skill mix right and the wider context of other workforce groups, along with the importance of multi-disciplinary working in modern healthcare.

1.81 The work led by National Institute for Health and Care Excellence will be overseen by an independent advisory committee for staffing. This will consider the evidence and draft the guidance, but it will also be able to signal the need for changes to existing tools where the evidence clearly indicates that there is an urgent need for them to be updated.

1.82 **NHS provider Trusts should therefore, from today, take account of the guidance issued by the Chief Nursing Officer and the National Quality Board.** They should follow this advice until guidance developed by the National Institute for Health and Care Excellence advisory committee for staffing is rolled out from Summer 2014.

1.83 From April 2014 and by June 2014 at the latest, **NHS Trusts will publish ward level information on whether they are meeting their staffing requirements**. **Actual versus planned nursing and midwifery staffing will be published every month; and every six months Trust boards will be required to undertake a detailed review of staffing using evidence based tools**. The first of these will take place in June 2014 and Trusts will be required to set out what evidence they have used to reach their conclusions. The second review, to be undertaken by December 2014, will use National Institute for Health and Care Excellence accredited tools. A review every six months will allow for the collection of several data points to inform appropriate staffing. **The National Quality Board will set the ground rules for publication of this data, which will form part of an integrated safety dataset that will be published on a single hospital safety website, covering the key aspects of safe care and in a form accessible to patients and the public.** This will be in the form of a table and will go down to ward or service level. Where the information on the website has the appropriate statistical validity, it will be used as part of the Care Quality Commissions Intelligent Monitoring. **The Care Quality Commission will take staffing and other data into account when making decisions about where to target its inspections: staffing data will form one of the 'smoke alarms' it will draw upon**. Commissioners will also use staffing data as a basis for further questions and discussions with providers.

1.84 The guidance issued by National Institute for Health and Care Excellence is not expected to include absolute staffing ratios given the inflexibility of such an approach, and the potential risks and disadvantages that the rigid application of ratios could have for patient

care. The guidance will, however, provide an evidenced, authoritative basis for staffing decisions. National Institute for Health and Care Excellence, NHS England, Health Education England, Department of Health and other national organisations will work together to ensure that NHS provider Trusts have the tools they need to make decisions to secure safe staffing; and these decisions will then be subject to external scrutiny and challenge by commissioners, regulators and the public, and inspection by the Chief Inspector of Hospitals.

1.85 Guidance is not enough on its own; leaders in care provider organisations need to develop strong and lasting engagement with their staff on this issue, so that there is a real understanding by decision-makers of the realities of care and a shared understanding of decisions about resources.

1.86 This response fully supports the further measures on safe staffing set out by the Chief Nursing Officer in *Compassion in Practice* and expect provider and other organisations to carry them out in full. **An important early action is to put in place regular public reporting of staffing levels and of whether or not safe staffing levels are being achieved.** Transparency is critical to ensuring safe staffing: it provides those with a legitimate interest in staffing levels (the public, patients, commissioners, regulators, staff) with clear information as a basis for assurance or further action, and makes it much more difficult to disguise staffing problems. In some Trusts, transparency is being taken even further. Actual versus expected staffing levels are being published on a shift by shift basis in some clinical areas. Salford Foundation Trust and Wrightington, Wigan and Leigh Foundation Trust have put this measure in place; and Central Manchester Foundation Trust plan to do the same. All Trusts should **put in place measures to increase transparency on staffing at ward and service level as quickly as possible.**

1.87 Transparently and openly publishing data about staffing levels is an important part of providing assurance to the public and to staff themselves about safety. NHS organisations will be expected to discuss and explain at public Board meetings their rationale for planned staffing levels and then publish on a monthly basis actual and planned staffing for each shift, highlighting wards or other clinical settings frequently failing to meet expected levels. Staffing will form part of a wider set of data on safety including the NHS safety thermometer which will enable data to be available to boards and to the public. This data also needs to be consistent with national safety reporting Care Quality Commission inspection data and 'Intelligent Monitoring' so that safety issues can be identified and acted on consistently outside Care Quality Commission inspection cycles. Where concerns are highlighted, Trusts will be expected to provide an explanation for their commissioners and Care Quality Commission and to work with their commissioners to develop an action plan to address those concerns. A joint statement between NHS England and the Care Quality Commission is being published setting out how the two organisations will align their work to support inspection and surveillance work for safety.

1.88 Health Education England have been working with NHS trusts to develop the overall workforce plan for England for 2014-15, reflecting strategic commissioning intentions. **This work indicates that a number of trusts have already increased their nurse staffing levels during 2013-14 and others are planning to do so**. Initial plans indicate that Trusts intend to employ an increase of over 3,700 nurses in 2013–14.

1.89 In addition to the external challenge provided by commissioners, the Chief Inspector of hospitals has also made it clear that appropriate **staffing levels are part of what the Care Quality Commission will look at when it inspects hospitals**.

1.90 The Department of Health is revising the registration requirements that all providers must meet, so that they incorporate new fundamental standards of care. Under these new standards, **providers will still be required to make sure they have sufficient numbers of suitably qualified, skilled and experienced staff to deliver their services.** The Care Quality Commission will set out in guidance how providers should meet this requirement. Care Quality Commission will work closely with National Institute for Health and Care Excellence and others who are supporting the development of guidance on safe staffing. In their assessments Care Quality Commission will look at how providers are using such guidance to ensure they meet people's needs.

1.91 The challenge of achieving safe staffing while also meeting other resource requirements must, of course, be seen in the context of a particularly challenging financial context. The Government commitment to ring-fence the NHS budget has enabled the number of clinical staff to increase in recent years. In July 2013 NHS England published *The NHS Belongs to the People: A Call to Action*, which highlighted the challenge faced by the NHS to ensure it is financially sustainable in the coming years. ***A Call to Action*** **begins a national conversation on how commissioning, led by local doctors and health professionals and working with patients and the public, will ensure the best hospital care possible.** The Spending Review 2013 set out that the NHS will need to continue to increase productivity and make substantial efficiency savings to deal with rising demand and cost pressures[xiii].

1.92 The Department of Health is working to ensure that these challenges are faced through maximising the resources available for front-line services as much as possible, building on and embedding recently announced workstreams to:

- increase investment in technology;
- make savings in administrative costs, procurement, drugs;
- improve the NHS's recovery of funds from international patients who are liable for their healthcare costs; and
- ensure efficient use of NHS land and estates.

1.93 Staffing is not simply about the crude numbers and it is not just about nurses. The number of staff needed to provide safe care will vary according to skill mix, clinical practice and local factors and it is right that nurse leaders have the freedom to agree their own staff profiles. **Setting staffing levels must take into account available evidence, local circumstances as well as the acuity and dependency of the patients being cared for.** This can change from ward to ward and in different clinical settings. Staffing levels must be flexible and responsive to local need and supported by the right culture, environment and education. Ratios can be a helpful guide to indicate safe staffing levels but can become a ceiling as well as a floor. Mandating staffing ratios is a blunt instrument which does not take account of the needs of the patients being cared for or the skill mix of the staff providing that care. The use of evidence based guidance and tools to inform staffing levels gives flexibility to respond dynamically to changes in patient demand and workforce supply.

1.94 The delivery of high quality care can only happen if the staff employed to undertake this work are suitably trained, competent and have the right values. **It will be the responsibility of Health Education England to provide national leadership and strategic direction for education, training and workforce development.** Health Education England will work with stakeholders to ensure that there are sufficiently highly trained staff to achieve a balance between supply and demand in terms of numbers, skills, and behaviours to support the delivery of high quality care now and in the future.

1.95 The government's responsibility is to support organisations within the system to ensure safe staffing by providing adequate resources for the NHS; by promoting progressive and innovative practice; and by ensuring the right forms of challenge and scrutiny are in place. Poor decision making and a lack of engagement with both staff and the best evidence are the critical issues here, and the measures outlined in this response and in *Compassion in Practice* and Sir Bruce Keogh's Review are designed to ensure that better, wiser decisions about staffing are made.

CONCLUSION

1.96 The NHS is rising to the challenge of creating a culture of safe, compassionate care. The Government and other national bodies will support the NHS to ensure the voices of patients are heard, safety and compassion are prioritised, and staff wellbeing is promoted. There is further information supporting staff in chapter 5. Next we turn to detecting problems quickly.

Chapter 2 – Detecting problems quickly

'We need a patient centred culture, no tolerance of non compliance with fundamental standards, openness and transparency, candour to patients, strong cultural leadership and caring, compassionate nursing, and useful and accurate information about services'.

Robert Francis QC

SUMMARY

In response to the Inquiry's report, we are putting in place measures to detect problems in the healthcare system quickly through fundamental standards of care, improved information sharing and a new inspection regime. It sets out action to ensure that

- Inspections are led by expert teams, including clinicians and service users (recommendation 51);
- There are clear **fundamental standards** of minimum safety and quality which must be provided, complemented by discretionary **enhanced quality standards** and longer term **developmental standards** (recommendation 13); and
- Regulators should share all intelligence that may indicate concerns about the quality of care (recommendation 35).

Patients and the public are entitled to expect that when problems occur in the NHS, they are detected and dealt with promptly. That is why the Government, working with the Care Quality Commission, is putting in place an effective and powerful system of hospital inspection, headed by the new **Chief Inspector of Hospitals**. The Care Quality Commission through its Chief Inspector will draw upon a new, clear and focused set of **fundamental standards** that will set out a clear bar below which care must not fall. In addition, it is critical to emphasise the crucial role played by **boards** in putting in place effective governance for their organisations as a means of ensuring issues are identified. Finally, detecting problems quickly depends upon **working together** at local and regional levels through **quality surveillance groups**, and also through co-operation between key national organisations.

Since Robert Francis issued his report:

- Professor Sir Mike Richards, the Chief Inspector of Hospitals, issued a 'call to action' to draw in patients and clinicians into expert inspection teams (recommendation 51).

- Monitor, Trust Development Authority and Care Quality Commission have reviewed the process of assessing applicant trusts and have agreed that no Trust will go forward for authorisation as a foundation trust unless and until it is rated 'good' or 'outstanding' under Care Quality Commission's new inspection regime (recommendation 65).
- In April 2013, Monitor published a guide for Boards on how to ensure its organisation is working effectively to improve patient care (recommendation 74).

Key future actions highlighted in this chapter include:

- By the end of 2015, the Care Quality Commission will systematically conduct inspections of all acute trusts (recommendations 53-59).
- The development of fundamental standards (recommendations 13-18).
- To protect against actual or perceived political interference in the independence of the Care Quality Commission the Government is legislating to enhance the statutory independence of the regulator (recommendations 53-55).
- Monitor will be publishing an updated Code of Governance for Foundation Trusts in early 2014 (recommendation 74).

This chapter addresses themes and issues raised in the following chapters of Robert Francis' report: Chapter 2: The Trust; Chapters 9-11: Regulation.

2.1 Patients and the public are entitled to expect that when problems occur in the NHS, they are detected and dealt with promptly. That is why the Government, working with the Care Quality Commission, is putting in place an effective and powerful system of hospital inspection, headed by the new **Chief Inspector of Hospitals**. The Care Quality Commission through its Chief Inspector will draw upon a new, clear and focused set of **fundamental standards** that will set out a clear bar below which care must not fall. In addition, it is critical to emphasise the crucial role played by **boards** in putting in place effective governance for their organisations as a means of ensuring issues are identified. Finally, detecting problems quickly depends upon **working together** at local and regional levels through **quality surveillance groups**, and also through co-operation between key national organisations.

Effective inspection

2.2 *Patients First and Foremost* stated that generalist inspection had run its course. Since then, the Care Quality Commission has appointed Chief Inspectors of Hospitals, Adult Social Care and General Practice.

Inspecting hospitals and listening to patients

2.3 The first of these appointments was **Professor Sir Mike Richards as Chief Inspector of Hospitals.** Sir Mike has set out his planned approach to inspection, which he is now putting into action with the first set of inspection visits. The 18 Trusts selected for the first wave of inspection represent the full range of predicted risk in patient care. Following the inspections (which will be completed by the end of the year) the results of all them will be published. By the end of 2015, the Care Quality Commission will have inspected all acute hospitals in England.

2.4 Sir Mike has made it clear that he will build in a far larger role for the public and for expert clinicians in the inspection process. There will be open listening events for the public and staff at the start of each inspection. **Since Sir Mike's 'call to action' in July 2013, 5,025 clinicians and 2,446 patients have offered to take part in inspections**. Inspectors will spend more time listening to patients, service users and the staff who care for them. They will also speak directly to senior managers and board members. Inspection will include a closer examination of records, and crucially, inspection visits will not just take place from 9 to 5; they will also happen at night and at weekends. The Chief Inspector and his inspectorate are committed to complete openness about where good and bad care is being delivered, and **Sir Mike has made it known that he will not tolerate poor or mediocre care.**

2.5 The approach to hospital inspection will be risk based: the time spent and the size of the inspection team will depend on a combination of factors that go to make up the risk of a hospital: the type of care offered, the vulnerability of the circumstances of the people who use it, the information the inspectors have about the service and its current rating. The results of the **Care Quality Commission's intelligent monitoring** will be published quarterly and was published for the first time on 24 October 2013 This divided Trusts into six bands based on data from more than 150 indicators. A risk appraisal of all 161 acute trusts was published on 24 October[xiv].

2.6 The Care Quality Commission will use the different sources of evidence available to it to predict more quickly the services that are failing, and to determine its programme of hospital inspections. In cases where the Chief Inspector judges that problems are intractable at a hospital and where there are significant concerns, he will place the hospital into the new hospital failure regime by giving it a warning notice requiring it to make significant improvement within a specified time. The Trust board, working with Monitor or the NHS Trust Development Authority will then be responsible for addressing the failures identified by the Chief Inspector. The Care Quality Commission will retain clear legal powers to take swift and decisive action if patients are at immediate risk of harm. **Where the Chief Inspector/expert inspectors find immediate risks to patients they will not only be able to require that appropriate action is taken through the single failure regime, they will also be able to ensure that the service or ward in question is closed immediately, until the risk is addressed.**

The Chief Inspectors

While the focus is on hospital services in the first instance, a new Chief Inspector of General Practice and Chief Inspector of Adult Social Care took up post in the Care Quality Commission in October 2013, and Care Quality Commission will produce sector specific guidance for all of the areas that it regulates.

The three Chief Inspectors will engage the public, professionals and providers in developing guidance for all sectors. Attention will be given to how the fundamentals of care are presented to the public, in particular so as to clarify the relationship to rights under the NHS Constitution and consumer rights.

The Chief Inspectors of Social Care and General Practice have been developing their approaches and priorities, and will be engaging patients, service users and the public in the weeks and months ahead. They will spearhead the extension and development of the new inspection approach that has started in hospitals, to their respective sectors, and together will ensure that the Care Quality Commission is providing assurance that health and adult social care services join up seamlessly from the perspective of people who use services.

Standards with consequences

2.7 There was no shortage of standards and processes for measuring them in the case of Mid Staffordshire NHS Foundation Trust. What was lacking was a well-understood means to do anything about failures to meet basic standards, and, linked to that, any real clarity about which organisation providing oversight was responsible for what action.

2.8 The work done by the Care Quality Commission and partners to develop standards has therefore not just been about identifying the right content; it has also been about constructing the **clear decision-points and triggers for intervention** that failure to meet those standards will provoke.

Fundamental standards

2.9 The Department of Health has been working with the Care Quality Commission to develop a set of **fundamental standards**. These fundamentals will set a clear bar below which standards of care should not fall. **There will be immediate and serious consequences for services where care falls below these levels, including the possibility of prosecution.** The Care Quality Commission published the responses to its public consultation on 17 October 2013, which showed that there is agreement with the new approach. **The Department will consult shortly on the draft regulations which will set in legislation the fundamental standards of care that providers must meet. The new regulations will come into effect during 2014 and will apply to all providers of health and social care that are required to register with the Care Quality Commission.**

2.10 This patient and service user-focused description of what counts as fundamental makes clear that safe, compassionate care must be at the heart of all services**, and there**

must be swift and decisive action to deal with failures to uphold these standards. The prime responsibility for taking such action will fall to the Trust board; and there will be regulatory scrutiny of this action, and regulatory intervention where it falls short. The Care Quality Commission have made it clear that breaches in the fundamentals of care will not be considered in isolation. It will consider whether the breach was the result of isolated human error or because of a systemic failure within a service, hospital or organisation. The speed, quality and impact of the response to the breach will also be considered.

Fundamental Standards

The final set of standards will be subject to consultation, but are likely to include:

- Care and safety of patients and service users.
- Abuse, including neglect.
- Nutrition.
- Respecting and involving service users (person-centred care).
- Consent.
- Governance.
- Cleanliness and safety of premises and equipment.
- Staffing.
- Fitness of Directors.
- Duty of candour.

2.11 The Care Quality Commission's approach to standards has been designed around categories that are meaningful to patients and service-users, and will look at whether a service is safe, effective, caring, responsive and well-led. The standards will be given legal force through the new regulations which will come into force during 2014.

Care Quality Commission review

The Care Quality Commission has carried out a significant review of how it uses information to identify potential failures in the quality of care in hospitals in relation to five key questions – is a service safe, effective, caring, responsive and well led? Well-led means that there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation, and an open, fair and transparent culture that listens and learns from people's views and experiences to make improvements.

The review undertook to define an 'ideal' set of indicators that Care Quality Commission could routinely monitor to identify these potential failures. A short list has gone through a formal consultation as part of *A new start – Consultation on changes to the way Care Quality Commission regulates, inspects and monitors care*. For 'well led' the proposed indicators were:

- NHS staff survey – responses to questions asking if 'Care of patients is top priority?'
- Junior doctor survey – overall satisfaction score
- Survey of trainee nurses
- Staff sickness rates
- Bed occupancy
- Monitor and NHS Trust Development Authority ratings of governance risk and financial risk

Care Quality Commission has commissioned the King's Fund and the University of Lancaster to advise on evidence-based approaches to assessing leadership and culture. This work will build on Monitor's Quality Governance Framework and recently published guide for Boards on Quality Governance and Monitor and Care Quality Commission are working together to align their approaches.

Enhanced and developmental standards

2.12 NHS England has commissioned the National Institute for Health and Care Excellence to produce quality standards. These are not mandatory but NHS England's guidance to commissioners makes clear that they must have regard to standards as the benchmark for specifying high quality – enhanced – care. **The Chief Inspector of Hospitals will take National Institute for Health and Care Excellence's quality standards into account when judging whether to award a rating of good.**

2.13 Within its quality standards, National Institute for Health and Care Excellence will set out developmental statements where there is an appropriate evidence base in an emergent field. Developmental statements represent practice that has the potential to have wide-spread benefits in improving outcomes over time, but which require specific developments to be put in place. The Chief Inspector of Hospitals will take National Institute for Health and Care Excellence's developmental statements into account when judging whether to award a rating of outstanding.

2.14 Taken together, the fundamental, enhanced and developmental standards will provide a framework for the Chief Inspectors, and a basis for ratings. Simply setting out a clear hierarchy of standards will not, of course, in itself generate the insight and understanding to promote improvement and to tackle poor care. The oversight provided by the Boards of organisations and the way that the inspectors operate will also be critical, and we therefore turn to these subjects next.

Speaking out safely

2.15 Many of the measures set out in this response are designed to ensure that the NHS is a genuinely open and transparent culture, a culture that will make whistleblowing far less necessary than at present. There will always, however, be a need to ensure that staff who have concerns are able to raise them. We therefore made it clear in *Patients First and Foremost* that NHS staff should feel free and able to raise their real concerns about patient care, and that the era of gagging staff must come to an end. The Government has acted to ensure this becomes a reality by:

- Extending to all healthcare professionals the **protections of the Public Interest Disclosure Act 1998** (which inserted Part 4A into the Employment Rights Act 1996) by the Enterprise and Regulatory Reform Act, which received Royal Assent in April 2013;
- Giving the new Chief Inspector of Hospitals an important role in ensuring hospital inspections are not just seen as a 'tick box' exercise by judging **whether the culture of the organisation actively promotes the benefits of openness and transparency**;
- **Enabling staff to whistle blow to health and care professional regulatory bodies as of 1st October 2013**;
- Backing the Whistleblowing Helpline's refresh of the '**Speak up for healthy NHS' guidance**, as recommended in its Bridge the Gap campaign report of July 2013.

2.16 The Government has also acted on compromise agreements, updating guidance in March 2013 to make clear that **where a compromise agreement is used it must include an explicit clause making clear that nothing within the agreement prevents an individual from making a protected disclosure under the Public Interest Disclosure Act.** The National Audit Office has now recommended other Government Departments adopt this policy. It examined a number of agreements and found no evidence of gagging clauses in any of the health-related cases they reviewed. This shows that the system has operated, and continues to operate, effective controls in this area. However, organisations still need to be vigilant to ensure staff do not feel constrained by agreements, which is why **NHS Employers launched guidance in April 2013 suggesting some model confidentiality clauses and model wording for the explicit clause now required in NHS compromise agreements**.

Clear, strong governance: the role of boards

2.17 Boards play a critical part in shaping the culture of care organisations, and in ensuring that problems are detected and dealt with quickly. This is only partly about the explicit policies and objectives they set, it is also about the behaviour of senior leaders, and the things they prioritise and devote their time to. Public statements, however strongly made, of what matters that are not followed through behaviourally by those in leadership positions are unlikely to be

seen as credible by the people asked to make change happen. Recording a commitment to engagement and listening in the Board minutes without then following through day to day is unlikely to convince staff and people using services that their views are taken seriously. **The evidence from the best performing organisations is that demonstrating a real commitment to the changes in culture agreed at senior level is critical in making successful change.**

2.18 To support Boards with quality governance Monitor published in April 2013 a guide for Boards on how to ensure its organisation is working effectively to improve patient care. Monitor will also be publishing an updated Code of Governance for Foundation Trusts in early 2014 which will make recommendations to strengthen corporate governance in light of the Francis report. Care Quality Commission inspections will also assess whether Trusts are well-led.

Scrutiny and asking good questions

2.19 Good Board members ask good (which often means difficult) questions, and good executive teams respond thoughtfully and not defensively to those questions. In order to do this well, boards need to promote an open and transparent culture within the organisation, and create a climate in which critical inquiry and discussion are used to improve the way the organisation works. A mature organisation is one that welcomes scrutiny of this kind and uses it as the basis for improvement by following up good questions with action; and then with further questions to check that change has really happened. **The behaviour of senior figures in the organisation will make all the difference in this: their genuine engagement with staff and a focus on improvement and achieving high standards and not on blame sends important signals throughout the organisation.**

Northumbria Healthcare: Developing a meaningful patient experience programme

Northumbria Healthcare NHS Foundation Trust provides acute and community health services and adult social care to a population of over half a million people in Northumbria and North Tyneside. The Trust runs nine hospitals (three general hospitals plus six community hospitals) and employs about 9,000 staff. The high level of engagement means that every day, somewhere in the organisation, somebody will be having a conversation about patient experience.

The views of more than 30,000 patients are listened to every year through. This is achieved using a wide range of different methods, including short exit surveys with patients about the quality of the care that they received, 'real time' face-to-face interviews with over 500 patients each month, while they are still in the Trust's care, and patient perspective surveys conducted once people have left hospital, to have a more rounded view of their experience of their care – evidence suggests that patients are likely to be at their most dissatisfied two weeks after discharge. All data is fed back to clinical teams allowing the Trust to act rapidly on patient feedback.

Innovative infographics have been developed to ensure that experience results are shared with patients, families and the public. Posters are updated each quarter so that the latest results are always on display.

The programme has helped to engage and support staff. In the annual NHS staff survey, the Trust performed exceptionally well, with 94 per cent of staff feeling that their work makes a real difference.

Commissioning for quality

2.20 Commissioners have a vital role to play in detecting problems quickly. It is clear that this did not happen in Mid Staffordshire NHS Foundation Trust. The development of clinically-led commissioning and the measures being put in place to ensure far stronger patient and public involvement in shaping services, along with improvements to contracting processes will all help to ensure that there is a richer and more robust dialogue between commissioners and providers which puts the patient and improvements in the quality of care at its heart. Commissioners will need to focus on spotting quality problems early, and on working with providers to improve pathways of care that learn the lessons of previous issues.

Working together

2.21 One of the most important findings of the Inquiry was the lack of communication and understanding between the different organisations with a responsibility for providing oversight, support and challenge to Mid Staffordshire NHS Foundation Trust. A culture of working within the narrow confines of single organisations was allowed to grow up. As with other failings highlighted by the Inquiry, the picture across the system as a whole is more mixed, with some examples of excellent joint working, as well as issues that must be addressed.

2.22 The arrangements for regulators and commissioners that the Department of Health has put in place and continues to develop in response to the Inquiry have been designed to ensure that the distinct roles and responsibilities of different organisations as well as the issues and areas they need to co-operate on are clear and unambiguous.

2.23 This means both making a clear distinction of roles and putting in place structures for sharing information and joint decision-making where they are needed. To give an example of making a clear distinction of roles, the Care Quality Commission will now focus on assessing quality and publishing its findings rather than intervening to drive improvement – which falls to the NHS Trust Development Authority and Monitor. **Care Quality Commission, Monitor, the Trust Development Authority, NHS England and the Department of Health published a joint policy statement** *The regulation and Oversight of NHS Trusts and Foundation Trusts* in May 2013.

2.24 The NHS Trust Development Authority, Care Quality Commission and Monitor have already improved the Foundation Trust authorisation process to learn the lessons from the first Inquiry and ensure stronger focus on quality. The assessment process now includes reviews of patient surveys, quality metrics and interviews and meeting with patient groups, staff, local commissioners and Healthwatch. A review of quality governance in the Trust is also undertaken. Monitor, the NHS Trust Development Authority and the Care Quality Commission are now undertaking a complete end-to-end analysis of the authorisation process, to ensure the process embeds fundamental standards, common set of quality measures and that it is a seamless process. In addition, Care Quality Commission will inspect Trusts prior to application, and no Trust will go forward for authorisation unless and until it is rated 'good' or 'outstanding' under Care Quality Commission's new inspection regime. In April 2014 Monitor and Care Quality Commission will implement a joint registration and licensing system.

2.25 In order to ensure that the different organisations with an interest in quality are aligned at local and regional levels, the National Quality Board has supported the development of a network of **Quality Surveillance Groups.** The local Quality Surveillance Group act as a virtual team across a health economy, bringing together organisations with information about and insight into the quality of care. This will include commissioners, system regulators, representatives of local authorities, Healthwatch, Local Education and Training Boards and public health. At regional level, Quality Surveillance Groups also include representatives of professional regulators, Health Education England and the Health Service Ombudsman.

2.26 The Quality Surveillance Groups will focus on the following questions:

- What does the data and the soft intelligence tell us about where there might be concerns about the quality of care?
- Where are we most worried about the quality of services?
- Do we need to do more to address concerns or gather intelligence?

Once concerns are identified, action can be taken swiftly by the relevant organisation.

Quality Surveillance in the south of England

In the south of England, a provider of community services for children and young people with mental health problems raised with NHS England an alert that there was significant risk to children and young people, due to local difficulties in providing the right level of care. It was taken to and discussed with the local Quality Surveillance Group, following which a dedicated Quality Surveillance Group meeting for all members with a specific focus on children and young people's mental health services was held. Subsequently, to ensure children and young people were kept safe, the Quality Surveillance Group oversaw progress against actions agreed locally. The issues were raised at a national level by the regional network of specialised commissioning. In addition, the Children and Maternity Network provided support to develop benchmarking and quality assessment tools for placements and transfers between targeted provision in the community and NHS England agreed the appointment of case managers to support care at the right levels. Within three months of the Quality Surveillance Group raising the alert, an agreement had been reached to develop an effective new pathway for supporting children and young people between these levels of service, something which had been under discussion locally for the previous five years without resolution.

2.27 At national level, the organisations with a responsibility for ensuring the quality of care have taken on board the need to be clear and explicit about how they are going to work together. In many cases, co-operation agreements or memoranda of understanding have been published which make this plain, and which act as a standard against which the behaviour of the organisations that have signed up to them can be judged[xv]. Of course, agreements on paper are no substitute for well-functioning, mature relationships; but they do provide a basis for both developing such a relationship, and for holding the signatories to account.

2.28 Detecting problems quickly is a necessary but not sufficient in tackling poor care. It must be followed by clear, swift and decisive action. It is to this that we turn next.

Chapter 3 – Taking action promptly

'Organisations in difficulty can succumb to the temptation of emphasising apparent achievements at the expense of recognising adequately the need for substantial improvements.'

Robert Francis QC

SUMMARY

In response to the Inquiry's report, we are taking steps to ensure we have a responsive healthcare system which acts to ensure quality and safety are maintained:

- It is clear to staff and the public whether organisations are delivering the fundamental standards (recommendation 24);
- The fundamental standards will enable prosecutions of providers to occur in serious cases where patients have been harmed because of unsafe or poor care, without the need for an advance warning notice (recommendation 28); and
- Applications for Foundation Trust status should focus on the standard of service delivered to patients and sustainability (recommendation 67).

Patients and the public are entitled to expect services that are failing to be dealt with swiftly and decisively. Improvement is primarily the responsibility of providers themselves and commissioners working in partnership to improve standards. The regulatory framework will be based on a single version of the truth that is clear about the respective roles of the different regulators, and which provides them with the tools that they need to intervene when required. **Clear and meaningful ratings** will be accompanied by **clear, risk-based intervention**, from warning notices, special measures, service redesign through to, in a rare number of cases, the special administration process.

Since Robert Francis published his report:

- The 11 Trusts in special measures have been partnered by successful Trusts working under 'improvement contracts' (recommendations 28-32).
- The Health and Safety Executive has brought a prosecution against Mid Staffordshire NHS Foundation Trust for the death of a patient during the period of the failings at the organisation, and this case is awaiting sentence. (recommendation 90).

- The Care Quality Commission has consulted on a new system of ratings with patient care and safety at its heart (recommendation 287).
- Legislation to introduce a responsive and effective failure regime which looks at quality as well as finance is progressing through Parliament (recommendations 27, 32).
- In October 2013 Monitor introduced a Risk Assessment Framework for NHS Foundation Trusts which will allow Monitor to track risk and trigger enforcement action (recommendations 62, 81).

Key actions highlighted in this chapter include:

- The Chief Inspectors will make judgements about providers using a set of clear and meaningful ratings (recommendation 287).
- Trusts aspiring to Foundation Trust status will have to achieve 'good' or 'outstanding' rating prior to any successful authorisation (recommendation 65).
- Monitor also has a range of enforcement powers in NHS Foundation Trusts that include compliance requirements, requiring certain actions to be taken, removal of Directors and revoking of an Foundation Trust's licence (recommendation 83).
- Care Quality Commission, Monitor and Trust Development Authority will publish further guidance on how they work together to address quality after April 2014 (recommendation 4).
- Where Foundation Trusts are placed in special measures, they will have their freedom to operate as an autonomous body suspended (recommendation 28).

3.1 Patients and the public are entitled to expect services that are failing to be dealt with swiftly and decisively. The basis for such action will be a set of **clear and meaningful ratings.** In most cases, this will take the form of support and further regulatory oversight. Clear, meaningful ratings will be accompanied by **clear, risk-based intervention**, from warning notices, special measures, service redesign through to, in a rare number of cases, the special administration process. Subject to the passage of new regulations, in 2014 the Care Quality Commission will have new powers to act immediately if it considers that patients and service users are at immediate risk of harm, without first having to issue a formal warning. Monitor published enforcement guidance in March 2013 on how it plans to obtain compliance in NHS Foundation Trusts where there are breaches of health care standards specified by Care Quality Commission, NHS England and statutory regulators of health care professions.

This chapter addresses themes and issues raised in the following chapters of Robert Francis' report: Chapter 8: Performance management and Strategic Health Authorities; Chapters 9-11: Regulation; Chapter 20: Culture.

Clear, meaningful ratings

3.2 All NHS Trusts and NHS Foundation Trusts will be inspected, and all will be given a rating that will be published. The rating given to each Trust will be primarily based on inspection judgements, informed by a series of indicators drawing on existing data and the findings of others such as clinical peer reviews and the judgements of other regulators. In order to make them more meaningful to the public, ratings will be provided for certain

individual services (such as emergency or maternity services) as well as for the hospital as a whole.

3.3 Inspection against standards will produce ratings, and different ratings will link clearly to consequences for NHS acute trusts. There will be four ratings:

- **Outstanding:** sustained, high-quality care over time across most services along with evidence of innovation and shared learning;
- **Good:** the majority of services meeting high-quality standards and deliver care which is person centred and meet the needs of vulnerable users;
- **Requires improvement:** significant action required by provider to address concerns
- **Inadequate:** serious and/or systemic failings in relation to quality.

3.4 The consequences of these ratings are clear. **Trusts aspiring to Foundation status will have to achieve a 'good' or 'outstanding' rating under the new inspection regime.** Monitor have made it clear that it will not approve Trusts for Foundation status without robust assurance from the Care Quality Commission that applicants are providing a good quality of care for patients. **Where Foundation Trusts are placed in special measures, they will have their freedom to operate as an autonomous body suspended**. The category of 'outstanding' will allow us to recognise the truly excellent NHS acute Trusts that are providing sustained high-quality care across different specialties.

3.5 It is vital that we ensure that only the best performing trusts are awarded Foundation Trust status and are therefore given the increased levels of autonomy and independence that this status brings. This increased focus on quality will mean that it will take beyond 2014 to ensure that all remaining NHS Trusts become Foundation Trusts or attain an alternative sustainable form. The timescales to reach Foundation Trust status will be set on a case-by-case basis for each trust by the NHS Trust Development Authority to ensure that improvements in quality are not compromised by a rush to achieve Foundation Trust status.

Clear, risk-based intervention

3.6 The story of Mid Staffordshire NHS Foundation Trust is the story of a failure that nobody knew what to do with. A pervasive culture of 'patch it up and keep going' (often with the best of intentions and the worst of results) made it difficult for those in regulatory and supervisory roles in the system of the time to see the failure let alone deal with it. This must change, and we are bringing in measures to ensure that it does.

3.7 The Department of Health has put in place a regulatory framework that is clear about the respective roles of the different regulators, and which provides them with the tools that they need to intervene when required. **The regulatory regime will be based around a 'single version of the truth' grounded in standards and ratings through inspection. Under the single failure regime, clinical unsustainability will be grounds for failure procedures just as financial unsustainability is at present.** Care Quality Commission, Monitor and Trust Development Authority will publish further guidance on how they work together to address quality after April 2014. The new inspection regime that the Care Quality Commission are putting in place will make it far less easy to hide away failure from public view, or from the view of commissioners, or other regulators. A new honesty about the relative quality of services

and of acute trusts will provide a basis for tailored and proportionate intervention that puts patients first and put things right promptly.

3.8 In October 2013 Monitor introduced a Risk Assessment Framework for NHS Foundation Trusts, including those that provide mental health services. This uses a set of national metrics on access, outcomes, patient satisfaction, Care Quality Commission judgements and reports from General Medical Council, the Ombudsman, commissioners, Healthwatch, patient groups and Royal Colleges to allow Monitor to track risk and trigger enforcement action.

3.9 It is essential that commissioners play a strong part in taking action promptly: they will often be the people outside the provider organisation who will have the first indications that there are problems with the quality of care. Commissioners have a number of means available to them to address quality problems (see chapter 4) and it is vital that regulators and oversight bodies work closely with them to ensure that the needs and interests of the local population are put first.

Warning notices and enforcement action

3.10 Inspection will not achieve this by itself, and it should not try: the inspectors' role is to focus solely on telling the unvarnished truth about the providers of care that they inspect[xvi]. Where care is found to be wanting, action must follow. **Very often this action will fall primarily to the provider organisation itself, and the Care Quality Commission through its Chief Inspector of Hospitals will issue 'warning notices' in relation to specific failings in care identified by inspection teams where significant improvement is required.** Monitor also has a range of enforcement powers in NHS Foundation Trusts for securing improvement in performance where there are breaches of health care standards. The powers include compliance requirements, requiring certain actions to be taken, removal of Directors and revoking of an Foundation Trust's licence. The importance of leadership within provider organisations discussed in chapter 2 becomes more important than ever: boards that fail to respond swiftly and constructively to issues raised by the inspectorates or indeed by other sources of insight such as Healthwatch, are failing as the leaders of their organisations.

Special measures

3.11 In the case of NHS provider trusts, beyond the boards of the organisations themselves, Monitor and the NHS Trust Development Authority will play a key role in ensuring that the right action is taken to put the trust back on track when significant issues have been identified by the Care Quality Commission.

3.12 **Where an NHS Trust or Foundation Trust has been placed into special measures by the NHS Trust Development Authority through its accountability framework or by Monitor through the provisions of the licence it grants to Foundation Trusts, the board of the Trust will need to demonstrate to the relevant body that it is credibly and effectively addressing the issues that have been raised.** Following Sir Bruce Keogh's review of 14 Trusts with high mortality rates, 11 of the Trusts reviewed were placed into special measures. Each of the 11 Trusts, as part of the new commitment to openness, have published its improvement plan on NHS Choices and will provide monthly updates so that the public can see what progress has been made. The 11 Trusts are being partnered

by successful Trusts working under **'improvement contracts',** an innovative measure for getting the most experienced and successful leaders in NHS hospitals to help those who are struggling.

3.13 In order to ensure that issues are addressed as quickly as possible, **the Department of Health is seeking changes to the legislative framework through the Care Bill to provide Monitor with the power to provide additional licence conditions on Foundation Trusts that have been issued with a warning notice by the Care Quality Commission.** The NHS Trust Development Authority already has powers that allow it to intervene in NHS Trusts that have received a warning notice.

Service redesign and administration

3.14 Most cases of failure in respect of fundamental standards will be addressed through action taken at Trust Board level, on occasion with support from the regulators and other Trusts through the special measures process. In some cases, however, the Trust in question may be in an unsustainable position in respect of the quality of care, or financially – or possibly both. In a case of this kind, local commissioners, supported by NHS England would be expected to resolve the issues at a wider system level through service redesign. Where this does not succeed in resolving the issue, the use of **special administration** provides a mechanism for ensuring that issues are addressed. Under special administration, the Trust Board is replaced by a special administrator by the Secretary of State (in the case of an NHS Trust) or Monitor (in the case of a Foundation Trust). The proposals in the Care Bill are designed to ensure that this action can be taken in the case of clinical as well as financial unsustainability. There will be close co-operation between the Care Quality Commission, the NHS Trust Development Authority and Monitor to decide whether to place a Trust into special administration. Where there is uncertainty over how to proceed, and the Chief Inspector believes that special administration would be appropriate in a case of clinical unsustainability the Care Quality Commission would, subject to the legislative changes the Department of Health proposes to make, be able to direct Monitor to start special administration or the Trust Development Authority to advise the Secretary of State to start special administration proceedings.

CONCLUSION

3.15 The changes brought about as a result of the Francis Inquiry has led to a system with a much more clearly graduated set of interventions in response to failings in care. Clear, meaningful ratings provide the basis for clear, risk-based interventions in the interests of patients.

3.16 In addition to action to put things right, the public are entitled to expect robust accountability in the NHS. We turn to this next.

Chapter 4 – Ensuring robust accountability

'The public are entitled to expect leaders to be held to account effectively when they have not applied the core values of the Constitution, or are otherwise shown to be unfit for the role.'

Robert Francis QC

SUMMARY

In response to Robert Francis' report, we are clarifying the levels of accountability within the NHS and the wider system so that:

- People found to be incompetent or guilty of serious misconduct will be disqualified from taking other senior roles (recommendation 80);
- Care providers, and directors and senior individuals within those organisations, should be criminally liable if they falsify information that they are required to provide by law (recommendation 182);
- Commissioners rather than providers should decide what they want provided (recommendation 130); and
- Department of Health officials should connect more to the NHS through visits and personal contact with people who have suffered poor experiences (recommendation 289).

Putting in place a clear and well-functioning system of accountability in the NHS is a critical condition for creating a culture of safe, compassionate care. The **Boards of hospital trusts** are responsible for holding their own organisation to account through strong, constructive challenge and for accounting to the public about its performance. The **professional regulators** are key role to safeguarding high professional standards and clinical competence. Effective **commissioning** rooted in clinical insight and service user and public engagement will hold providers to account for delivering safe and compassionate care. This chapter also addresses the role of **Government** and the vital work of **coroners and medical examiners.**

Accountability must apply to individuals as well as to organisations. Board members must be committed, capable and qualified to uphold leadership positions in the NHS. That is why we are introducing a new **fit and proper person's test** regulated by Care Quality Commission for Board level appointments. This means that there will be a clear duty on all service providers to make sure that all Directors who are appointed to the Boards of any health or care organisation regulated by Care Quality Commission are suitable for the job. This will apply

to providers from the public, private and the voluntary sectors. NHS England will explore the development of a **parallel set of arrangements for clinical commissioning groups.**

Since publication of Inquiry's report:

- The clinical commission group assurance framework requires clinical commissioning groups to be authorised by NHS England who will continue to scrutinise performance based on outcomes and who have the power to intervene if necessary (recommendation 123).
- Local quality surveillance groups, which involve a range of stakeholders, have been formed to share information and address quality of care.
- NHS England is reviewing the standard NHS contract to make it easier for commissioners to intervene when they have concerns about patient safety or outcomes (recommendation 31).
- The Department of Health has initiated a 'connecting' scheme, so that policy makers are in touch with the front line (recommendation 289).

Key actions highlighted in this chapter include:

- A fit and proper person's test to be used as a mechanism for barring Directors who are unfit from individual posts by Care Quality Commission at the point of registration.
- Contracts will be reworded to make it easier for leaders to be removed when their Care Quality Commission ratings are unsatisfactory (recommendations 79-80).
- Criminal sanctions for care providers that falsify certain information required by law.
- Healthy NHS Boards' guidance.
- Monitor guidance for Boards on how to ensure its organisation is working effectively to improve patient care (recommendations 176-177).
- The Government, Care Quality Commission, Trust Development Authority and Monitor will work with NHS Employers to promote the use of existing mechanisms in place to support successful leadership and address failures in leadership eg recruitment, appraisal and exit procedures (recommendation 80).
- A detailed consultation on the role of medical examiners and death certification will be published by Government (recommendations 275-281)

This chapter addresses themes and issues raised in the following chapters of Robert Francis' report: Chapter 5: Mortality statistics; Chapter 7: Commissioning and Primary Care Trusts; Chapter 14: Certification and inquests relating to hospital deaths; Chapter 19: The Department of Health; Chapter 20: Culture; Chapter 21: Values and Standards; Chapter 24: Leadership in Healthcare; Chapter 26: Information.

The responsibilities of Boards and leaders

4.1 The problems at Mid Staffordshire NHS Foundation Trust became systemic and toxic because the people in charge of the Trust led it badly, and did not address the negative culture and the pressures on staff that grew up over a number of years. The decisions made by leaders on their own or collectively have a huge impact on the people they serve and on

the communities around them. The behaviour that they display influences the behaviour of others in their organisation and helps to shape the culture for good or ill. Good leaders and good governance are therefore critical to the successful development of a new and positive culture in health and social care.

4.2 The relationship between the people who lead a healthcare organisation and the people who work for it is a key determinant of its success. The senior leadership teams that get this right (including the non-executive Directors) recognise that their organisation relies on the skill, motivation and behaviour of the people providing care to patients and of the people supporting them to care. Understanding how well the organisation is doing requires understanding how well its people are doing; and this is not something that can be discerned solely by spreadsheets and surveys (helpful as they can be). It is about talking with staff, opening up a space in which concerns can be shared and challenges worked through together. It is also about Boards asking themselves how well they are doing in taking account of the NHS Constitution.

4.3 Sometimes it is simply about saying 'thank you'. It is also about ensuring that the resources available to the organisation are used as effectively as possible so that staff have time to care.

4.4 The leadership of an NHS provider organisation is the job of the Board of that organisation. The Mid Staffordshire Board failed to provide leadership and proper scrutiny and challenge. Sir Bruce Keogh's review highlighted failures in Board leadership at a number of organisations[xvii]. **Boards must take responsibility for the culture and performance of their organisations while also acting as a source of internal scrutiny and challenge.** The temptation to fall back into simply defending the organisation and advancing its interests is strong; but Boards that do this risk not seeing the real issues and problems of their organisation. As set out in the recently published *Healthy NHS Board*, Boards need to be supportive of their organisations but not at the expense of their critical distance: sometimes an organisation's board needs to be its harshest critic. All too often, Boards have avoided this role. Professor Don Berwick's review rightly emphasised the importance of putting in place a culture that was committed to learning, and this is something that must be supported and reinforced by boards and leaders. In this context, the role of non-executive directors is critical.

The Healthy NHS Board 2013 – Principles for Good Governance

The Healthy NHS Board 2013 – Principles for Good Governance sets out the guiding principles that will allow NHS board members to understand the:

- Collective role of the Board including effective governance in relation to the wider health and social care system
- Activities and approaches that are most likely to improve Board effectiveness in governing well
- Contribution expected of them as individual Board members

It is primarily intended for boards of NHS Trusts and Foundation Trusts and with some interpretation it is relevant for organisations operating at a national level. It is not intended for clinical commissioning groups but it does offer a framework to help them to place reliance on the effective governance of provider organisations.

The guidance will also be of interest to those aspiring to be NHS board members, to governors of Foundation Trusts who have a role in ensuring that the board operates effectively and to those who support and work with NHS boards.

It aims to describe the enduring principles of high quality governance, that transcend immediate policy imperatives and the more pressing features of the current health care environment.

Ensuring quality and safety: the role of Boards

4.5 Ensuring quality and safety has to start from the top of organisations. As the recent revision of *The Healthy NHS Board* made clear, organisations are quick to notice what the people at the top spend their time on, and adjust their behaviour accordingly[xviii]. Strong, visible leadership at Board level is therefore vital. Monitor's recent guide for Boards on quality governance stresses they should focus on strategy, capabilities and culture, processes and measurement for delivering high quality care. This leadership needs to be of the right kind: you cannot create a learning culture through fear and arbitrary interventions. If boards want to lead learning organisations, they have to show a commitment to learning and improvement themselves, asking difficult questions about patient safety in public as well as private, and involving staff and patients in developing solutions.

4.6 Of course, tools and transparency only help if the people leading organisations are genuinely committed to using them, and see their core mission as delivering safe and compassionate care. The lesson of the Francis report and of Professor Berwick's report is clear: organisations throughout the NHS have to commit to making patient safety a reality. Heartfelt commitment is needed, not superficial compliance. **All organisations should consider how they make this commitment visible to their staff and to the public in the months and in the years ahead.**

4.7 The Department of Health will support and encourage trusts and their Boards, to improve data quality locally, to use it more effectively and to better understand its role in improving services and helping Trusts to listen to patients' views. Monitor already has in place

programmes provided in partnership with others to support provider chairs, non-executive directors and finance directors and has also committed to developing support for chief executives and medical directors. Monitor is also planning a series of mini-seminars on key areas of challenge for Board directors.

Developing the board's own capability

4.8 Boards must take responsibility for their own competence and development. This applies at both an individual level and collectively. This means taking an honest and objective look at the gaps and limitations in the capability of the Board, and putting in place action to improve.

4.9 Sir Bruce Keogh's review sets a number of pertinent challenges to Trust Boards, including those set out in his first two 'ambitions' to make demonstrable progress towards reducing avoidable deaths rather than debating mortality statistics; and for Boards and leaders to be confident and competent in using data for the forensic pursuit of quality improvement.

4.10 While it is for Trusts to agree roles and responsibilities of its Board members locally, information on the quality of services is essential to improving services to support good quality care and identifying potential issues as they arise. Monitor's guide for Boards asks them to consider whether they have appropriate information that is robust and allows levels of quality to be benchmarked.

4.11 The NHS Trust Development Authority states, as part of its *Accountability Framework for NHS Trust Boards* (April 2013), that they will review the skills and competences of executive and non-executive Board members. As part of the oversight process the NHS Trust Development Authority will require trusts to assess whether *'… all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including … monitoring and managing performance'.* The NHS Trust Development Authority will escalate issues that it finds in order to ensure that they are resolved appropriately.

Fit and proper persons

4.12 The public has the right to expect that people in leading positions in NHS organisations are fit and proper persons; and that where it is demonstrated that a person is not fit and proper, they should not be able to occupy such a position. Monitor and the Care Quality Commission are committed to ensuring that, taken together, their processes for registration and licensing reflect these principles. Monitor already requires providers not to appoint as a Director any person who is an undischarged bankrupt, individuals who have served a prison sentence of three months or longer during the previous five years, and disqualified Directors. It requires providers to terminate the contracts of persons who become unfit. In July 2013 the Government issued a consultation on *Strengthening Corporate Accountability in Health and Social Care.* This proposed **a new requirement that all Board Directors (or equivalents) of providers registered with Care Quality Commission must meet a new fitness test.** This will apply to providers from the public, private and the voluntary sectors.

4.13 **The Government will establish a new fit and proper person's test for Board level appointments, which will mean that the Care Quality Commission is able to bar**

Directors who are unfit from individual posts at the point of registration. This will apply to providers from the public, private and the voluntary sectors. Where a Director is considered by Care Quality Commission to be unfit it could either refuse registration, in the case of a new provider, or require the removal of the Director on inspection, or following notification of a new appointment. Further details will be set out in the response to the consultation on corporate accountability which will be published shortly. The Government plans to publish the draft regulations for consultation at the same time. The Government believes that the barring mechanism will be a robust method of ensuring that Directors whose conduct or competence makes them unsuitable for these roles are prevented from securing them. The scheme will be kept under review to ensure that it is effective, and we will legislate in the future if the barring mechanism is not having its desired impact.

4.14 This work has drawn upon the Professional Standards Authority's publication *Standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England*[xix]. These standards provide a helpful basis for the fit and proper test. NHS England will explore the development of a parallel set of arrangements for clinical commissioning groups.

4.15 In addition to regulatory mechanisms, **it is also important for organisations appointing and employing senior leaders to use the means already available to them (most notably recruitment, appraisal, exit procedures and provision of references) to ensure and strengthen the quality of the senior leaders in their organisations and the wider system, and to identify and deal with issues of performance and behaviour promptly and effectively.** This will on occasion (but not always) include action to remove someone from a senior role. The Government, Care Quality Commission, the NHS Trust Development Authority and Monitor will continue to work with NHS Employers and other organisations with a responsibility for and an interest in these issues to ensure a focus on improving the way that existing mechanisms operate. The focus for this issue should be the internal processes described above, and the Care Quality Commission's registration requirements rather than the constitution of the Foundation Trust. An appropriate clause will be drafted for inclusion in the Very Senior Managers model contract. NHS Employers will be commissioned to work with the Care Quality Commission, NHS Trust Development Authority and Monitor to develop guidance to support the effective performance management of very senior managers in hospitals through appraisal, ensuring relevant links are made to the Chief Inspector's ratings and individual contracts.

False or misleading information

4.16 The Inquiry established evidence that the Trust repeatedly made inaccurate statements about its mortality rates (paragraphs 22.4-22.11) which led, in part, to a lack of action to investigate issues regarding the quality of care both within the Trust and by other bodies.

4.17 It is already a requirement of Monitor's licence that information provided by licensees is accurate, complete and not misleading. **However in the Care Bill, the Government has introduced a new criminal offence applicable to care providers that supply or publish certain types of information that is false or misleading, where that information is required to comply with a statutory or other legal obligation.** The offence will also apply to directors and senior managers who have consented or connived in (or are negligent

in relation to) an offence committed by a care provider. Subject to the passage of the Bill, this new offence will improve transparency and allow poor care to be addressed earlier. It will enable action to be taken against a provider who is found to have made significant falsifications in information that they are required to provide by law.

4.18 Providers that make a genuine administrative error would not be convicted, providing they have processes and procedures in place to demonstrate they took all reasonable steps and exercised due diligence. Prosecutions will only be brought if the error is material and it is in the public interest to do so.

Breaches of fundamental standards

4.19 Where a provider has been successfully prosecuted for a breach of fundamental standards, an individual Director can also be guilty of the offence where the breach was committed with their consent or connivance or through their neglect. For individual healthcare professionals, Monitor and the NHS Trust Development Authority have a range of intervention powers. For example, Monitor is able to remove, suspend or replace NHS Foundation Trusts' Governors or Directors. The NHS Trust Development Authority is able to remove Directors in NHS Trusts. In instances where an individual is found to have caused death or serious harm, existing legislation can be used by the appropriate authority to hold them to account, as has happened with staff who were charged with neglect or ill-treatment at Winterbourne View.

The role of professional regulation

4.20 The standards set by professional regulators provide practitioners and the public with clear descriptions of the behaviour expected from professionals. A number of measures are being put in place to ensure the regulatory framework for professionals is strengthened and made more responsive in the light of the Inquiry's report.

4.21 The recent announcement by the Nursing and Midwifery Council on the measures it is putting in place to support the revalidation of nurses was a welcome development. Revalidation has the potential to have a significant positive impact on the quality of care for patients.

4.22 The Inquiry's report emphasised the importance of professional regulators working more closely and systematically with system regulators. The General Medical Council, the Nursing and Midwifery Council and the Care Quality Commission have all accepted the need to do more to share information, align processes and work together to improve.

4.23 The Government will continue to support the work of the **Law Commission** regarding legislation to make it quicker and easier to tackle poor professional practice or behaviour.

4.24 It is important for patients, employers and professionals themselves that complaints and concerns about health professionals are investigated quickly. While some cases are legally complex or may have to await the completion of police investigations before they proceed, it is reasonable to expect that the overwhelming majority of cases are investigated and resolved or brought to a hearing within no more than 12 months and the General Medical Council is already achieving this. The professional regulatory bodies are currently hampered by a cumbersome and complex inheritance of legislation, but the Government has asked the Law Commission to review this and bring forward proposals to simplify and modernise

professional regulation law. We will seek an early opportunity to legislate, enabling all the professional regulators to move rapidly to a maximum 12 months period for concerns raised about professionals to be resolved or brought to a hearing, in all but a small minority of cases.

Commissioning for quality, safety and compassionate care

4.25 The issues identified by the Inquiry's report in relation to commissioning include:

- A lack of clarity about the remit and purpose of commissioning organisations;
- A lack of co-operation and information sharing between commissioners and regulators;
- An excessive focus on the financial bottom line and on the management of what could be easily measured rather than what mattered to patients; and
- A lack of focus on the quality of care and patient experience.

4.26 Commissioners made little if any difference to the care of patients in Mid Staffordshire NHS Foundation Trust. Commissioning failed as a means of defence against poor care, and as a promoter of high quality care. The picture in the wider NHS and in social care has been more mixed. Over the past 20 years, commissioning has helped to deliver a range of improvements in quality, access to care, productivity and efficiency; but it has often failed to have the transformational impact on the quality of care that had been hoped for.

4.27 The fundamental purpose of setting up commissioning arrangements by splitting purchasers from providers of care was to ensure that the interests of the public were clearly and unambiguously represented by commissioners who purchased care on their behalf. This has perhaps been too narrowly understood in the past in terms of getting best value for money (with emphasis more on the money than the value) but if commissioners are going to become the trusted advocates of the public interest that they were originally intended to be, they must be able to demonstrate that they are unequivocally focused on the interests of patients, service users and the public and not on those of the system. The key to achieving this is strong clinical leadership accompanied by real and meaningful engagement of patients, the public and service users.

4.28 The main aim of commissioning is to improve outcomes for patients. In doing this, commissioners (NHS England and clinical commissioning groups alike) must consider how the quality and efficiency of services might be improved by a range of means, including through services being provided in a more integrated way, and through the adoption of evidence-based innovative approaches. They must take steps to identify existing and potential providers interested in, and capable of, providing the services and consider when it would be appropriate to enable providers to compete to provide services, and allow patients a choice of provider. In making procurement decisions, they will take into account a number of factors, such as Care Quality Commission ratings, and a range of performance, quality and outcomes information, including patient feedback on their experience.

4.29 **The changes to commissioning brought in by the 2012 Health and Social Care Act provide a basis for ensuring far stronger clinical involvement in commissioning than before**: a critical lesson of both the Inquiry and of the recent history of commissioning. Stronger clinical leadership means the ability to lead service transformation, creating a sense of direction, managing resources effectively and influencing and engaging colleagues.

Clinically-led clinical commissioning groups put doctors, nurses and other health professionals at the heart of commissioning, with an explicit focus on improving health outcomes for the whole population and reducing inequalities in health.

Examples of improving care outcomes by clinical commissioning groups

Improved care for Chronic obstructive pulmonary disease patients in Coventry

GPs in Coventry and Rugby have developed a consultant-led community chronic obstructive pulmonary disease team to increase the number of patients with chronic obstructive pulmonary disease (COPD) staying out of hospital. An audit revealed that 74% of Chronic obstructive pulmonary disease patients admitted to hospital made contact with their GP practice in the month before their admission, and 58% had received three or more courses of antibiotics in the year prior to admissions. Strong clinical engagement was vital, as was the development of the consultant-led community Chronic obstructive pulmonary disease team which provides high quality care for patients, helping them to self-manage and stay healthy and out of hospital. Funded from the reduction in admissions and outpatient appointments, the community Chronic obstructive pulmonary disease team achieved a reduction in the number of patients with Chronic obstructive pulmonary disease needing to be admitted to hospital, resulting in an improved quality of life and slower disease progression for patients. Patient satisfaction with the service scored at 98%.

Advance care planning for end of life care

Ipswich clinical commission group engaged clinicians from ambulance service, hospitals, hospices, out of hours care and care homes in discussions to improve advance planning of end of life care with patients. The aim was for patients to be able to choose their place of death, reduce patient and carer distress and unnecessary hospital admissions. Through better communication between the different providers and agencies, and a coordinated approach the clinical commission group has achieved improved integration across end of life services. 54% of people in East Suffolk died in their own home in 2012–13 compared with 48% in 2010–11. For patients in a participating care home at the time of their death, 7% of deaths occurred in hospital compared to 19% of deaths among patients in care homes not participating in the scheme.

4.30 Other aspects of the commissioning system create wider opportunities for clinical leadership of and involvement in commissioning. **Strategic clinical networks** bring together doctors, nurses and other health professionals to drive change and improvements in the areas of cancer, coronary heart disease, mental health and maternity and children's services. In addition, **clinical senates** bring together clinicians from all sectors of health care, patients and other partners, to give advice to commissioners and providers in their area to help them make the best decisions they can for the populations they serve.

4.31 Clinical commissioning groups must have at least two lay members on their governing body, and they must commission on the basis of plans drawn up with their local health and wellbeing board: this helps to put public and patient involvement at the heart of commissioning as never before.

4.32 The Department of Health has also strengthened the focus on commissioning for outcomes through the outcomes frameworks for public health, the NHS and adult social care. This means commissioners and providers of care are focusing on what matters most for patients and service users, including their experience of care.

4.33 In developing the new commissioning framework, NHS England, in its roles as both a direct commissioner of care and as source of support and challenge to clinical commissioning groups, has sought to apply the lessons of the Francis Inquiry at every opportunity. The authorisation process for clinical commissioning groups included scrutiny of their ability to commission safely and improve quality. **Following authorisation, NHS England will continue to hold clinical commissioning groups to account for quality and outcomes as well as for financial performance, through the clinical commission group assurance framework. NHS England also has powers to intervene where there is evidence that clinical commissioning groups are failing or are likely to fail.**

4.34 In addition to this enhanced oversight of commissioning, focused on the quality of care, NHS England will also ensure that local commissioners of care are much more effectively linked to other local organisations with an interest in health and care. This will help to address some of the issues of organisational isolation identified by the Inquiry. Commissioners will be prominent members of local Health and Wellbeing Boards, which will bring together local commissioners of health, care and other services to work in partnership to improve outcomes for the whole population. In addition, **NHS England has convened new Quality Surveillance Groups in each area of the country.** From the perspective of commissioners, Quality Surveillance Groups offer a powerful basis for taking action on the basis of shared intelligence and information from local patients and services.

4.35 The basic tool available to commissioners is the contract. In the case of Mid Staffordshire NHS Foundation Trust (and also at Winterbourne view hospital) the contracting process had no real impact on the quality of care. **NHS England is therefore reviewing the provisions in the standard NHS contract in order to make it easier for commissioners to intervene when they have concerns about patient safety or outcomes. Details will be published in December 2013 as part of the NHS standard contract for 2014–15.**

4.36 NHS England undertook a review of incentives, rewards and sanctions between April and October 2013. The review identified the importance of incentives, rewards and sanctions in enabling the transformation of care, but also highlighted their limitations and wide variation in how they are applied in practice.

4.37 The review recommended that changes to national incentives, rewards and sanctions for 2014–15 should be made in tandem with changes to the payment system, and that any significant changes should be based on best available evidence. As a consequence, the focus of changes for 2014–15 will be on allowing maximum local flexibility to reward providers for genuine transformation of services, achieving higher standards or quality improvement, while otherwise maintaining stability and making incremental improvements to our existing incentives, rewards and sanctions.

4.38 The strategic intent of incentives should be to support delivery of NHS England's objectives through both direct and clinical commission group commissioning, within the context of ever tighter financial constraints. They must contribute to improved outcomes

through improvement in the quality of health services for patients, their families and carers, and reducing health inequalities, be that through encouraging transformational change or gaining greater value from our existing services. Some incentives (currently defined as contract sanctions) can also ensure basic standards of quality are maintained.

4.39 **Important as contracting is, good commissioning is much more than the specification of services and outcomes.** It requires a mature dialogue with providers and with other organisations in the health and care system to ensure that the long-term interests of the public are being safeguarded and advanced. This includes potentially difficult conversations about service design, in which commissioners must play a leading role. Just as provider organisations need to guard against their isolation from the wider community and the system of which they are part, so must commissioners, for it is only by working with and through other organisations and the public they serve that commissioners can have the best chance of preventing and tackling poor care of the kind we witnessed at Mid Staffordshire NHS Foundation Trust. Here, as elsewhere in the system, relationships really matter, and time and effort must be given to ensuring that they are real, robust and have an eye to the long-term as well as the issues of the day. **Excellent commissioning can address pro-actively the risk of services becoming unsafe by spotting trends in the population and responding by changing the nature of the services.**

Oldham clinical commission group and Oldham: Link involved local people in determining fairness in commissioning decisions

Taking on the challenge of explaining the rationale behind difficult commissioning decisions to the public and enabling people to participate meaningfully in this process, Oldham clinical commission group and Oldham Local Involvement Network (LINk) established the Oldham Health Commission into Fairness. Held over four days in April 2011, it involved a panel of members of the public hearing expert testimony from clinicians and others, before making recommendations on the principles and practice of fair healthcare commissioning. As a further opportunity for decision-making to be shaped by patients, the panel's recommendations were opened up for public comments via a website. The final set of recommendations was presented to the clinical commission group Governing Body to inform clinically-led commissioning in Oldham.

The role of Government

4.40 As the steward of the health and care system, the Department of Health has a critical responsibility to provide the right environment and support for the system as a whole to flourish. **It is vital that the Department, along with the rest of the system, learns the lessons of the Inquiry and addresses the issues of capability, skills, experience and leadership that the Inquiry has highlighted**.

4.41 The changes brought about by the Health and Social Care Act 2012 places a strong and clear responsibility on the Department of Health and its Ministers to act as the system steward. At times, this will mean that the Department has a responsibility to challenge the health and care system to improve on behalf of patients, service users and the wider public.

4.42 Since the publication of *Patients First and Foremost* earlier this year, the Department has put in place its **'Connecting' programme, enabling civil servants to spend time experiencing the realities of health and care services at over 75 locations throughout the country**. To date, there have been a total of 107 staff placements with a range of health and social care organisations, lasting a combined total of 545 days. There are a further 101 placements planned to take place before the end of March 2014, totalling a further 528 days. The programme is currently targeting our senior leaders, so the total of connecting experiences to date represents a high proportion of our senior staff – in fact over 90% of our senior leaders will have started connecting by the end of 2013. It is intended that connecting placements will be available more widely across the Department in 2014, following a review of the programme. The feedback from those involved in the first wave of the programme (predominantly but not exclusively senior civil servants) has been overwhelmingly positive. Many of the Department of Health staff who have participated in the programme thus far have remarked that the experience of engaging for a sustained period of time with organisations providing direct patient care has helped them to see policy issues with fresh eyes. The Department of Health will continue to roll out the programme so that every civil servant in the Department is able to benefit from this experience.

4.43 In addition, Departmental staff have also been participating in series of 'Francis Inquiry reflection events' in which the implications of the Inquiry for the Department as both a policy-making organisation and as the steward of the health and care system is discussed and debated by Departmental staff. The question of how the Department ensures that it plays its part in promoting a system centred on safe, compassionate, patient-centred care is not just being addressed by the leaders of the Department, it is also a key concern of staff throughout the organisation. The Department will continue to build on this broad engagement.

4.44 The Department's role as overall system steward means that it is responsible for ensuring that the different elements of the health and care system work coherently together towards the goal of safe, compassionate, patient-centred care. **In its role as sponsor of national bodies such as NHS England, Health Education England and the Care Quality Commission, the Department is responsible both for holding individual organisations to account and for ensuring common purpose across the health and care landscape.** The Department is determined to ensure that it remains strongly focused on the interests of patients and the public, supporting the health and care system to do well, and also identifying and confronting difficult issues whenever they arise**. In the language of a recent study of NHS culture and behaviour**[xx] **the Department, in its role as steward of the system, is adopting a 'problem-sensing' rather than a 'comfort-seeking' approach.**

The refreshed mandate to NHS England 2014–15

'The Government's response to the Francis Inquiry will seek to ensure that the commissioning, delivery, monitoring and regulation of healthcare brings about a transformational change that focuses on achieving reliably safe and high quality care, that puts patients at its heart and where compassionate care and patient experience are as important as clinical outcomes. NHS England's **objective** is to take forward the actions they have agreed in this response, working closely with its partners to achieve change with significant progress expected in 2014-15'.

4.45 The cultural change that the Inquiry called for in the NHS needs to have an impact on Government as well. Putting patients and those who care for them at the centre, and a recognition of the need to create an environment for safe, compassionate care, will be the guiding lights for the work of the Department of Health and for the development of the capability of its staff. By building on its 'connecting' experience, and by developing robust and purposeful relationships with other organisations in the system, and by being absolutely clear about its focus on patients and the public, the Department of Health will provide effective support and challenge to the health and care system as a whole. This also means listening to doctors, nurses and other health professionals. The Department has put in place arrangements to ensure that it has access to clinical advice on the full range of issues it deals with. The mechanisms employed include direct employment of clinical advisers where appropriate and also access to advice from senior clinicians elsewhere in the system. The Department recently appointed two Deputy Chief Medical Officers to support the Chief Medical Officer, and, is able to draw on the expert advice of Public Health England and NHS England in ensuring both medical and scientific input to public health policy development.

Department of Health – connecting with patients and people who use services

The Department of Health has introduced a programme of work aimed at improving its connections with patient and service user experience. Exposing staff to the realities of patient and service user experience at the point of care will, ultimately, help us make better policy. The programme aims to:

- enable Department of Health staff to gain sufficient exposure to patient and service user experience to be able to properly reflect this in their work
- ensure that policy making reflects the realities of patient and service user experience, as seen in the context of health and care settings
- give Department of Health's partners, stakeholders and the public assurance that Department of Health staff are connected to the experience of patients and service users
- help exposure to patient and service user experience become an integral part of Department of Health culture
- enable Department of Health staff to develop enduring relationships with partners providing care to patients and service users.

Department of Health is currently in contact with over 70 organisations across the health and care sector to establish connecting arrangements, including acute trusts, mental health trusts, community trusts, primary care providers, social care providers, clinical commissioning groups, third sector providers and public health organisations.

To date, there have been a total of 107 staff placements with a range of health and social care organisations, lasting a combined total of 545 days. Typical elements of the experiences that our partners have offered so far include experiences of acute care, mental health services, the work of third sector organisations and care homes. The range of experiences is constantly expanding.

A feedback process has been developed to ensure key lessons and intelligence from the connecting visits are captured and shared systematically within Department of Health. It is intended that connecting placements will be available more widely across the Department next year, following a review of the programme.

Coroners and medical examiners

4.46 The sharing and collecting of information with, and by, coroners is key to ensuring that deaths are properly investigated and that future deaths are prevented where possible. To support that the Coroners and Justice Act 2009 states that it is an offence to distort, alter or prevent evidence being provided for the purposes of an investigation, and it is vital that those responsible for disclosing information locally to coroners prioritise openness in sharing such information to support investigations into deaths.

4.47 In addition, the Chief Coroner's Office has issued further guidance to coroners regarding sharing *Reports to Prevent Future Deaths* (previously referred to as 'rule 43' reports) with the Care Quality Commission and the Judicial College will continue to develop training to support coroners' officers in undertaking their roles including how to involve the bereaved when gathering information.

4.48 A detailed consultation on the role of medical examiners and death certification will be published by the Government at the earliest opportunity, which will incorporate the draft regulations that will underpin many of the changes needed to support the Inquiry's recommendations. The role of the medical examiner, where deployed in sufficient numbers by the local authorities and supported by appropriate guidance and training, will begin to improve the accuracy of death certification and the consistency, and approach, in collecting information about a death including from the bereaved.

4.49 The Government agree that medical examiners must be independent of the deceased and their medical practitioner. However, in order to ensure that there are sufficient numbers of appropriate qualified and experienced medical examiners within every local authority we will not require that they are independent of organisation whose patient's death is being scrutinised.

4.50 **We intend to publish draft death certification regulations for medical examiners in England that will state clearly what is understood by independence, including independence from specified connections between the medical examiner and the deceased or the attending practitioner.** This will include familial, professional and financial connections between the medical examiner and either the deceased or the attending practitioner both in the present and the past.

4.51 To ensure that all medical examiners have the necessary skills and knowledge to undertake the role, they must be a registered medical practitioner, licenced to practice by the General Medical Council and with at least five years' experience. In order to ensure that there are sufficient numbers of independent, qualified medical examiners in all areas of England the draft legislation does not require that medical examiners are independent of the organisation whose patients' deaths are being scrutinised.

4.52 Where a medical examiner has any concern that their independence has, or will be, compromised they are able to raise those concerns directly with the appropriate local authority and/or the National Medical Examiner as needed.

4.53 It is the responsibility of local authorities to ensure that sufficient funds and resources are available for the functions of medical examiners to be effectively discharged. **To support local authorities in this task, the Department of Health will provide each local authority with estimated numbers of medical examiners that may be required locally based on expected levels of death and workload and match resourcing for medical examiners to that estimation.**

Chapter 5 – Ensuring staff are trained and motivated

'Leadership generally in the NHS is under challenge and needs more effective support. The necessary culture will only flourish if leaders reinforce it every day in every part of the service'.

Robert Francis QC

SUMMARY

In response to the Inquiry's report, the Government affirms the importance of the staff in the NHS and the value of ensuring they are properly trained and motivated to perform their role. We are working to ensure that:

- Nurse training should have an increased focus on the practical delivery of compassionate care, with recruitment focusing on values, attitudes, behaviours and motivation (recommendation 185);
- Any concerns about the standard of care should be shared with the relevant training regulator (recommendation 152); and
- A leadership college or training system should be created (recommendation 214).

The NHS is nothing without its staff. They make it what it is. Supporting staff is fundamental to ensuring good outcomes for patients, and a culture of safe, compassionate care. Real and meaningful **staff engagement** is an important source of improvement and, when done well, of insight that allows leaders to detect problems quickly. The Inquiry highlighted how quality, care and compassion need to be key to all **education and training**, with trainees and staff displaying the right values and behaviours for a career in healthcare. The Inquiry identified a number of issues in relation to **nursing** which are being addressed by nurses themselves and the organisations supporting them. Responding positively to the **Cavendish review of healthcare assistants and support workers** is critical to creating the right culture – looking at recruitment, training, development and supervision of this workforce; and at treating all patients and service users with care and compassion. Supporting staff by ensuring that **bureaucratic burdens** are tackled effectively is a key element of ensuring 'time to care' for staff. Finally, putting in place a positive **leadership culture** throughout the NHS will support the system as a whole to focus on its core mission of putting patients at the centre of care.

Since publication of the Inquiry's report:

- A new fast-track leadership programme has been launched to recruit clinicians and external talent to the top jobs in the NHS in England (recommendation 214).
- In September 2013, Health Education England began its first pilot of aspiring student nurses working as healthcare assistants (recommendation 186).
- Professional Regulators are working on education standards in medicine and nursing to place a significant emphasis on quality and compassion (recommendation 185).
- The Federation of Nurse Leaders has been developed to raise the awareness and profile of the nursing voice at national level (recommendations 203, 206).

Key actions highlighted in this chapter include:

- The Chief Inspector of Hospitals ratings and inspection regime will encompass staff engagement (recommendations 51, 195, 198).
- The Social Partnership Forum will develop a comprehensive description of what good staff engagement looks like for employers (recommendations 195, 198).
- Health Education England are leading the work with Skills Councils, other delivery partners and health and care providers to develop a new Care Certificate (recommendation 211).
- Health Education England is supporting employers to test values, attitudes and aptitude for caring during recruitment (recommendations 2, 191).
- Health Education England will review the content of pre-registration nurse education to ensure all new nurses have the skills to work with older people and will develop post-graduate training for nurses caring for older people with complex needs (recommendation 200).
- The Nursing and Midwifery Council has committed to introduce a proportionate and effective model of revalidation for nursing (recommendation 194).
- The Health and Social Care Information Centre will become the focal point for national data collection and will monitor new data collections to reduce 'burden' on providers and release time to care (recommendation 244).
- The NHS Leadership Academy's development programmes will see a range of NHS staff (particularly clinicians) learn to lead and achieve better, more compassionate patient care (recommendations 2, 185, 214).

This chapter addresses themes and issues raised in the following chapters of the Inquiry's report: Chapter 12: Professional regulation; Chapter 18: Medical training; Chapter 20: Culture; Chapter 21: Values and standards; Chapter 23: Nursing; Chapter 24: Leadership in Healthcare and Chapter 25: Common culture applied: the care of the elderly.

Staff engagement

5.1 Those with Board-level responsibility in organisations that provide care have one very significant advantage: the overwhelming majority of their staff are willing to give their time and energy to making services work better. Tapping this energy, and avoiding its frustration by a sense that 'no-one listens' is a central responsibility of leaders and Boards.

Staff engagement: Key messages

The Social Partnership Forum believes that we have an opportunity to use the Inquiry Report to emphasise fundamental strengths within the NHS workforce and challenge issues that need to be addressed. We also believe that staff are the biggest asset of the NHS and its greatest investment.

Our starting point is that staff and managers in the NHS want to provide compassionate care and to do their best for patients and families. Every day, in every ward, clinic and community, this is happening.

We need to continue to build on our strengths to develop positive working environments through:

1. Engaging staff and delivering good people management – which delivers better patient outcomes. This is highlighted in a growing body of research evidence (West et al 2011; Berwick 2013) and should be implemented with the rigour of a new drug or treatment.
2. Enshrining standards that build on the NHS Constitution, in particular for staff to have well designed jobs, access to appropriate training and education, support to maintain their health & wellbeing and safety and to be involved in decisions that affect them.
3. Obtaining staff feedback regularly and using this as an important barometer to gauge the quality of care and employment in an organisation. This needs to be done by all providers of NHS services whatever their sector as well as commissioners and regulators. We would urge that the NHS staff survey is completed by all providers of NHS services.
4. Safe staffing levels set by using evidence based tools and sound professional judgement. These are recognised as essential to good patient care and patient outcomes, but are only one component of establishing safe staffing. There also needs to be effective whole team working supported by good employment systems.
5. Strong and effective partnership working at a national, regional and, in particular, at a local level to maintain the positive elements of NHS culture. Working to deliver a cultural change so that staff feel able to raise issues of concern and know they will be listened to.
6. Supporting trade union representatives (safety reps, stewards and learning reps) who have a vital role to play in helping to establish and maintain a positive workplace environment, which has a direct impact on patient outcomes.

These six steps support developments of the right values, culture and working environment to ensure patients will benefit.

5.2 The Department of Health has been working closely with employer and staff representatives through the Social Partnership Forum Francis Sub Group, discussing how key areas such as staff engagement and safe staffing can best be driven forward in healthcare providers. The group have agreed on some key messages for the system, and will continue to distil the key messages of the Inquiry's report across staff and employers alike.

5.3 On 9th October 2013, the Department of Health announced a review to consider **options for supporting employee voices and their stake in organisations providing NHS services**. This will assess a range of options, including models such as social enterprises and mutual organisations.This will be led by Professor Chris Ham, Chief Executive of the King's Fund. He will be supported by an independent panel of experts from healthcare and other sectors. The review will identify the barriers preventing some NHS providers from engaging and empowering staff, outline good practices within the NHS and other sectors, and recommend how these can be adopted throughout the NHS. It will look in detail at the hospital sector but will also consider primary and community care and relationships with social care.

In it for the long haul

South Tees Hospitals NHS Foundation Trust understands that organisations wishing to change their culture have to be in it for the long haul. It began to focus on its culture in 1991, when it embedded organisational development practitioners as permanent members of staff, working alongside the Chief Executive and Director of Operations. This has led to a well-defined strategy about how to work in an open, supportive and safe way with teams in difficulty.

Its experience has shown that the key to culture change is commitment from senior leadership, and then commitment throughout the organisation, to be open, to speak and hear difficult messages and to take developmental action: because team difficulties are a threat to patient safety.

South Tees Hospitals NHS Foundation Trust suggests a number of practical things that NHS organisations can do right away to start building a healthy organisational culture. These include:

- consulting widely with staff to develop core values
- writing a code of behaviour and linking it to all staff contracts
- building leadership knowledge and skills about effective teamwork
- promoting debate about how people work together
- monitoring hard data trends such as clinical incidents, complaints, appraisal completion and sickness absence, alongside making better use of informal intelligence – what they previously called 'gossip', and working to make this soft intelligence part of 'what we know'
- encouraging leaders to pay attention and act when staff speak out about team difficulties.

To find out more see: www.southtees.nhs.uk/about/trust/operational-services/improvement-alliance/

Education and training

5.4 The development of staff must not end with their formal education. The role of training and of leadership development is critical in both reinforcing the expected standards and in supporting staff to address issues with their own practice. In addition to formal training, it is vital to recognise that one of the most powerful means by which all staff providing care learn how to behave is by observing the behaviour of others. The behaviour modelled by leaders and peers is very often the most powerful source of what is or is not acceptable.

5.5 **Health Education England, working with other organisations, will put in place a culture of learning as a key support for creating a culture of safety and compassionate care in health and social care. Education and training should be a running theme throughout a health and care practitioner's career**. Much has been done to respond to some of problems and deficits in the quality of education, training and professional standards highlighted by Robert Francis, but more remains to be done if the workforce is to be provided with the education and training it needs to provide the best possible safe and compassionate care.

5.6 It is vital that the staff of tomorrow are able to demonstrate not only academic and technical ability, but also that they have the values of kindness and compassion that are needed to care for patients in an emotionally demanding environment. Health Education England and Local education and training Boards, working with employers and education providers, are responsible for the development of the future workforce and have a key role to play to ensure that the current workforce is fit for purpose and able to provide care of the highest quality. Health Education England's role as the system leader in education and training, plus its focus on the patient, makes it a natural lead for the system's delivery of many of the recommendations in the Inquiry's report, through for example ensuring students have direct care experience prior to training, developing values based recruitment to assess prospective students on the capacity for compassionate care as well as technical ability, and ensuring that patient and student voice are genuinely built into their system for designing and monitoring quality of training.

5.7 Health Education England and other national organisations will work to support improvements in three key areas highlighted by the Inquiry:

a. **Continuous development and appraisal**: ensuring that education and training meets the development needs of the practitioner.

b. Education and training that **supports practitioners to work collaboratively as part of multi-disciplinary teams.** Too much education and training is undertaken within professional and practitioner boundaries which contrasts with modern ways of working and the needs of people using services.

c. Education and training that puts **quality at the centre**, supporting practitioners to be compassionate, safety-conscious and to genuinely listen to service users.

5.8 The primary responsibility for ensuring good educational provision falls to Health Education England and the Local Education and Training Boards. The responsibility for ensuring that the whole of a practitioner's career is one of continued development and improvement is a much more widely distributed responsibility, with the leaders and Boards

of care providing organisations having a particularly important role in ensuring that their staff are both sufficiently trained to do the job and are appraised and offered development opportunities and training that allows them to improve. Individuals working in health and social care must take responsibility for their own development, and act on concerns about the quality of their early placements and future training throughout their careers.

5.9 NHS England will support the development of the **patient safety collaboratives that will foster multi-professional working to promote patient safety**, as recommended by Professor Don Berwick. One model that NHS England will explore is regional collaboratives that are aligned with the new Academic Health Science Networks.

5.10 The Nursing and Midwifery Council revised its **education standards** in 2010 with a significant emphasis on care and compassion for patients. These standards have been gradually introduced by universities since September 2011 and all of them are expected to be compliant. The General Medical Council's Quality Improvement Framework introduced from 2011-12[xxi] seeks to deliver a process that amongst many things, will assure the public and the medical profession about the standards of medical education and training in the UK; drive standards in the quality of medical education and training; and engage employers, students, trainees, patients and the public to ensure that high quality education and training of the medical workforce is maintained.

5.11 As the Government made clear in the recent Mandate to Health Education England, education providers should be given the opportunity to address quality issues but this should not prevent information being shared with regulators and other partners to ensure that the interests of patients are protected. Health Education England should ensure that it monitors and acts on feedback from students and trainees as this provides an important measure of the effectiveness of their education and training. This should include ensuring that staff and trainee feedback is passed to the Care Quality Commission within one month of receiving it where concerns have been raised.

Nursing and compassionate care

5.12 For many patients, compassionate nursing makes all the difference; and the overwhelming majority of nurses work incredibly hard to offer genuinely personal and compassionate care and succeed in doing so– sometimes against the odds. If we want nurses and other people working in health and care providers to show compassion, we must treat them with the same respect and kindness: this applies to us all as patients and carers, but in particular to those with wider responsibilities in the health and care system. Supporting staff to care is a key theme in *Compassion in Practice,* the vision and strategy for nursing in England. *Compassion in Practice* describes the fundamental contribution that nurses, midwives and care staff make to help people stay healthy, recover from illness and be independent. The vision is underpinned by six fundamental values: the 'six Cs' of care, compassion, competence, communication, courage and commitment. The six Cs place a firm focus on putting the person being cared for at the heart of the care they are given. *Compassion in Practice* sets out a series of actions which will help to build and strengthen nurse leadership, support staff to work with people to provide a positive experience of care, and support a positive staff experience.

Compassion in Practice

Compassion in Practice, the nursing and midwifery strategy for all NHS and social care organisations, has already made a difference to the way care is delivered. The 6Cs has been a social movement, and almost every frontline nurse and midwife knows what the 6Cs means. The 6Cs implementation is supported by the 6CsLive! Website at http://www.6cs.england.nhs.uk where there are now examples of good practice across the country as a result of the implementation of *Compassion in Practice*.

The *Compassion in Practice* implementation plans can be viewed at: http://www.england.nhs.uk/nursingvision/actions

There are now over 200 Care Makers who are ambassadors for the 6Cs, creating a unique link between this national policy and strategy and the frontline. Care Makers are recruited for their passion for ensuring patient centred, compassionate care and role model these values both nationally and locally in their own organisations. Care Makers were initially student or newly qualified nurses and midwives, but the opportunity to be a Care Maker is now open to staff at all levels and we continue to recruit them.

Compassion in Practice has the ambition to ensure that patients and the people we care for have excellent compassionate care. Over the next two years the priorities will include:

- fully embedded 'every contact counts' into the NHS and social care
- building on the Family and Friends Test to improve the experience of patients and the people we care for
- ensuring all nurses and midwives are recruited for values and have regular appraisals which review their values
- continuing to ensure excellent leadership training for ward managers / team leaders and frontline staff
- working with National Institute for Health and Care Excellence to ensure we have the right staff in the right place in hospitals, the community, primary care and mental and learning disability settings
- ensuring staff have a good environment to work in so that they feel valued, are able to look after people to the best of their ability and demonstrate the 6Cs
- ensuring transparency of information

Safe, compassionate care for older people

5.13 If we can get safe, compassionate care right for older people, we are likely to be able to get it right for the rest of the population. Naturally, a large number of the people who use health and care services are older people. Many have multiple needs, and some may have different expectations of services than other age groups. Our proposals for named clinicians set out in Chapter One will be a central element of our approach, but other measures will also be necessary.

5.14 Integrating care services and ensuring real continuity for each person's care is critical, and will make an enormous difference for those with multiple needs, including many older people. The Government's development of a vulnerable older people's plan, which will be published later this year, is looking at how GPs can support greater integrated out of hospital care and provide proactive care management to avoid unnecessary hospital admissions and keep people well and independent for longer. The Government is committed to ensuring safe and timely discharges, and reducing unnecessary delays. Patients should never be discharged without the appropriate care and support in place. **The Government is supporting safe and timely discharges through spending £1bn between 2010 and 2015 on reablement services which help people to regain their independence and confidence following discharge from hospital. In 2015–16 the £3.8bn Integration Transformation Fund will bring health and social care commissioners together to plan services around people to improve outcomes and experiences.**

5.15 It is essential that those nurses caring for older people, whether in hospitals, care homes or the community, have the right compassion, skills and values to look after what can often be some of the most vulnerable people in our society. Alongside this, nurses need to continually have the most up to date knowledge and skills required to provide high quality care.

5.16 It is vital to recognise and not underestimate the complex challenge of caring for older people in any setting, many of whom may be advanced in years, have multiple health problems and live independently. They can often manage their long-term conditions themselves but may also need varying degrees of support from professionals. Other people may be much more frail, dependent and vulnerable in older age. There are of course variations in between these stages and people need and deserve individual care: one size does not fit all. The same is also true of nursing knowledge and skills.

5.17 All registered nurses at the point of qualification need to be competent in managing and implementing care for older people. As a nurse's career progresses **they must have the opportunity to specialise in the care of older people.** They must also have the right skills – not just their clinical expertise but also their decision-making and judgement skills, so that they can help navigate older people through the complex systems of health and social care. To do this they need to build from the firm foundation of their undergraduate experience to develop their expertise at each stage of their career. **This is why we are proposing to offer access to practical continuous professional development and have a clear and rewarding career path from novice to expert.**

5.18 **Health Education England, working with the Chief Nursing Officer, the Director of Nursing at the Department of Health and Public Health England and the nursing profession, will develop a bespoke older persons nurse post-graduate qualification training programme.** Completion of this training programme and demonstrable expertise in working with older people will allow nurses the opportunity to become part of an Older Persons Nurse Fellowship programme that will enable nurses in this field to access a clinical academic pathway. The first cohort of students will commence on the post-graduate programme in September 2014.

5.19 Malnutrition can be a significant problem, which can be both a cause and a consequence of ill health. The vast majority of malnourished people are in the community and statistics show that a third of older people are already malnourished or at risk of malnutrition on admission to hospital. Around 13,000 patients a year are admitted to hospital with a primary diagnosis of malnutrition – which will not include cases where malnutrition is an underlying or associated factor. **The Department of Health is awarding grant funding to the Malnutrition Taskforce, led by Age UK, to run stage 1 of a pilot programme to test a framework to reduce malnutrition among older people in a range of health and care settings.** The Malnutrition Taskforce's pilot will bring together the relevant professionals from a range of care settings, to work together to improve the care of older people at risk of malnutrition, raise awareness to help prevent people becoming malnourished in the first place, and help carers and clinicians identify and treat people with malnutrition more effectively.

5.20 As set out in Chapter One, Health Education England will introduce values-based recruitment for all students entering NHS-funded clinical education programmes. As part of its mandate for 2013-2015, the Government has asked Health Education England to implement improvements to GP training to include more emphasis on care of older people; work-based training modules in mental health, including dementia; and an understanding of working in multi-disciplinary teams to deliver good integrated care.

Nurse leadership

5.21 **Recognition of the importance of nurse leadership has led to the establishment of the Federation of Nurse Leaders, to raise the awareness and profile of the nursing voice at national level. The forum has members from the arm's length bodies, the Department of Health and Public Health England, and is chaired by the Chief Nursing Officer.** Nurse leadership is important throughout the system. It is not based on a hierarchy or through being in a position of power. Nurse leaders are all those who drive change through innovation, speak up to make improvements and motivate others to given exemplary care.

5.22 The Leadership Academy, supported by NHS England, is delivering the Prime Minister's commitment that 10,000 nurses and midwives will receive extra leadership training and support by the end of 2014–15. The number gives an idea of the scale of the Academy's work, but ultimately this is about real development opportunities for nurses and midwives – the majority of whom will participate in one of the Academy's new national professional development programmes.

Revalidation

5.23 The Nursing and Midwifery Council has committed to introducing a proportionate and effective model of **revalidation**, which is affordable and value for money, to enhance public protection. Subject to public consultation, the proposed model would require evidence that the nurse or midwife is fit to practise. Under the current proposals, the Nursing and Midwifery Council Code and standards would be reviewed and revised to ensure they would be compatible with revalidation, and guidance for revalidation would also be developed.

Direct experience of care

5.24 One of the most important things for securing compassionate care is making sure at the outset that the right staff, with the right capabilities and values, are recruited into posts involving direct care. **The Government has asked Health Education England to test the concept of up to one year of pre-degree care experience for aspiring student nurses, so that they are able to work out whether the career is suited to them, prior to starting a full nursing degree course.**

5.25 The pilot is an opportunity for aspiring nurse students to get real, paid caring experience for up to one year as a Healthcare Assistant before entering undergraduate nursing education, and to see if nursing is right for them and they are right for nursing.

5.26 In September 2013, Health Education England established the first set of pilots, and 150 to 200 aspiring student nurses began working as healthcare assistants. Health Education England is looking to introduce further pilots in February/March of next year. On completion the pilot will be evaluated to see how pre-degree care experience could be rolled out in an affordable and cost-neutral way, so that everybody who wants to train to be a nurse is able to get caring experience before they start their studies. The evaluation results of the pilot scheme will need to be considered in the context of the Nursing and Midwifery Council's pre-registration nursing standards 2010 and their application across the four countries of the United Kingdom.

5.27 Students will enter their nursing degree course with increased confidence that this is the career for them, along with a genuine and demonstrated aptitude for caring. In addition, all nursing degree programmes last at least three years and require the 50% of time is spent in practice learning and 50% in academic study. The first progression point cannot be passed unless the student undertakes a period of practice learning and assessment, and so nursing students will continue to gain experience in care environments throughout their studies.

5.28 Alongside this, work is on-going to make a career in nursing more accessible for those staff who already give care, as set out in the Government's Mandate to Health Education England.

Healthcare assistants and support workers in the NHS and social care settings

5.29 The need for continuous development and training as part of multi-disciplinary teams is particularly important for health and care support workers. The review undertaken by Camilla Cavendish highlighted the importance of this staff group to the health and care system: it is no exaggeration to say that without health and care assistants, the health and care system as we know it would not be able to function.

5.30 **The Government broadly accepts the findings of the review, which highlighted many examples of good training and support in both health and care settings and advocated learning from the best but also identified problems with consistency and quality across both sectors. The Government is committed to driving forward implementation to ensure healthcare assistants and social care support workers receive high quality and consistent training and support they need to do their jobs, taking into account the need to achieve affordability and value for money.** Many of the health and care support workers that took part in the review were making an enormous

difference to the lives of service users, and often gaining huge personal satisfaction from their work.

5.31 The Cavendish review also highlighted a number of significant issues and concerns. These included:

a. **The need to improve recruitment, training and education**

- The creation of the Care Certificate to ensure that Healthcare Assistants and Social Care Support Workers have the right fundamental training and skills in order to give personal care to patients and service users.
- Develop proposals for a rigorous system of quality assurance.
- Employers supported to test values, attitudes and aptitude for caring at recruitment stage. In Social care the National skills Academy should report on progress, best practice on their recruitment tool by Summer 2014.

b. **Making caring a career**

- Health Education England and Local Education and Training Boards to set clear implementation plan to take forward the objective to 'widen participation' in recruitment to NHS-funded course and develop funding routes for non- traditional staff to progress.
- Health Education England and Local Education and Training Boards should develop new bridging programmes into pre-registration nursing and other health degrees from the support staff workforce in health and social care, working with Skills for Care, the Nursing and Midwifery Council and Skills for Health.

c. **Effective leadership, supervision and support for health and care support workers:**

- The use of the title 'Nursing assistant'.
- How employers can be more effective in dismissing unsatisfactory staff.
- Trusts to empower Directors of Nursing to take greater Board level responsibility for recruitment, training and management of healthcare assistants.
- Skills for Health should refine its proposed code of conduct for staff, and the Department of Health should review the progress of the social care compact (which is now known as the social care commitment): and substitute a formal code of conduct for employers if a majority have not acted by 2014.

d. **Time to care – NHS England to look at the impact of 12-hour shifts on healthcare assistants and social care support workers.**

- NHS England to look at the impact of 12-hour shifts on healthcare assistants and social care support workers.
- The Department of Health should explore with the social care sector how to move to commissioning based on outcomes; and aim to eliminate commissioning based activity by 2017.

- Statutory guidance should require councils to include payment of travel time as a contract condition for homecare providers.

Recruitment, training and education

5.32 On 7 October, Earl Howe tabled an amendment to the Care Bill updating the provisions in the Health Social Care Act 2008 that would enable regulations to be made to specify a body that would set training standards in respect of healthcare assistants and social care support workers.

5.33 The Government has asked Health Education England to lead the work with Skills Councils, other delivery partners and health and care providers to develop a Care Certificate. This will provide assurance that healthcare assistants and social care support workers receive high quality training and consistent training and support they need to do their jobs. This should ensure that they understand the skills required and demonstrate the behaviours needed to deliver compassionate care across health and social care and help raise the status of caring.

5.34 Health Education England is leading the work in close partnership with Skills for Care, Skills for Health and other relevant partners. The objective would be to ensure that training is consistent and of high quality across both health and social care.

5.35 Health Education England is already supporting employers to test values, attitudes and aptitude for caring at recruitment stage under its mandate. For social care, the project on value based recruitment tools for social care was launched by Norman Lamb MP in July and will be piloted for 12 months.

Making caring a career

5.36 Health Education England is working on the delivery of its Mandate around widening participation and has initiatives to encourage a wider section of the community and existing care support workers, amongst others, into professional training to become nurses or other healthcare professionals. In addition, Health Education England is developing plans to further increase the number of healthcare apprentices, and is also exploring funding arrangements, through local partnership working, to develop and make best use of the talents of the existing NHS workforce.

5.37 Health Education England has agreed to lead this work with relevant stakeholders. It is already working on this through its Mandate for 'widening participation' working with employers to improve capability of the care assistant workforce. It will also build on the career pathway work that Skills for Care and Skills for Health have in place for health and other social degrees, to ensure that different programmes are transferable and comparable and support progression into a variety of healthcare professional and social care degree programmes, including developing new bridging programmes.

Effective leadership

5.38 The Chief Nursing Officer, working with a wide range of stakeholders, is considering the impact of of using the term 'Nursing Assistant', recognising that this would not apply to all healthcare assistant groups.

5.39 The Professional Standards Authority has been formally commissioned to lead work, along with relevant stakeholders, to develop practical proposals for managing the dismissal of unsatisfactory staff more effectively.

5.40 The Chief Nursing Officer will lead work to empower Directors of Nursing to take greater Board level responsibility and will work in partnership with key stakeholders. The intention is to link this piece of work to *Compassion in Practice National Strategy for Nursing, Midwifery and Care Staff*, Action Area 4 on 'Leadership' and Action Area 5 'The right staff, with right skills, in the right place'.

5.41 Skills for Health and Skills for Care published a Code of Conduct for support workers in March 2013 and they will review the code to ensure the language is readily understood and that there is synergy with the social care commitment for adult social care workers.

5.42 In addition, the Department of Health has developed a Social Care Commitment which launched in September 2013. This is the sector's promise to provide people who need care and support with safe, high quality services. In order to make commitments employers, care workers and carers sign up to statements that focus on values and behaviours and pledge to complete tasks that support the statements.

5.43 The Commitment will have a key role to play in helping to improve public trust in the care sector. From December 2013, once a Care Quality Commission registered care provider has signed up to the Commitment, the public will be able to see this on their NHS choices profile. At the same time the public will be able to search the Social Care Commitment website and see which organisations have signed up, including any non Care Quality Commission registered providers.

5.44 Department of Health will monitor the impact of the Commitment before considering any requirements through a formal code of conduct.

Time to care

5.45 The Chief Nursing Officer has agreed to look at the issue of time to care and lead the work with relevant stakeholders, recognising this would not apply to social care support workers.

5.46 The Government agrees to a move toward better commissioning based on outcomes rather than activity, or for slots of time, and wants to encourage local authorities to do so to help deliver better quality care for people who need care and support. Designating 15 minutes can be an unrealistic time to complete tasks during a home care appointment in most instances. The Government amended the Care Bill so there is an explicit requirement for local authorities to consider people's wellbeing when commissioning services-planned to take effect from April 2015, subject to parliamentary approval. We are also gathering ideas through the Home Innovation Challenge of how to make homecare better. Later in the autumn we will set out how this will continue to make a difference to future Homecare. The Department of Health will also be working with the Association of Directors of Adult Social Services to develop a set of 'commissioning standards to support and drive continuous sector led improvements across the country. We expect these to be developed by April 2014 and then to be used when they have been tested for effectiveness.

5.47 The Government agrees with the concerns that Camilla Cavendish raises about whether some employers not paying for travel time between home care visits is leading to some workers receiving less than the national minimum wage. Payment of travel time is a requirement of regulation 15(2b) of the National Minimum Wage Regulations 1999. The Department for Business Innovation and Skills provides guidance based on the regulations on the gov.uk website which sets out what counts as working time when calculating national minimum wage. This guidance says that for all types of work, working time includes 'travelling from one work assignment to another.' Non-compliance with the law on this is unacceptable. The Government is taking action to address this and to improve compliance with national minimum wage legislation including Her Majesty's Revenue and Customs targeted enforcement activity on non-compliance in the care sector. Alongside this enforcement activity we will develop statutory guidance for local authorities which refers to employment law and to the Department for Business, Innovation and Skills guidance on payment of travel time, to assure themselves that the care companies they contract with comply with National Minimum Wage regulations.

Disclosure and barring service

5.48 The Disclosure and Barring Service took over the functions of the Criminal Records Bureau and the Independent Safeguarding Authority in December 2012, and issues criminal records certificates and makes independent decisions about who should be placed on the barred lists[xxii].

5.49 There is a legal duty for providers, including NHS organisations, care homes and domiciliary care agencies, to refer people to the Disclosure and Barring Service. They must refer if they think a member of staff or volunteer has harmed, or poses a risk of harm to service users and, because of that risk, they have stopped them providing care. Making these referrals will ensure that people who are barred because they pose an ongoing risk to service users are prevented from moving from one provider to another.

5.50 In addition to the legal duty to refer, it is an offence to knowingly employ people who are barred from certain activities, and organisations can apply to the Disclosure and Barring Service for an enhanced Disclosure and Barring Service disclosure with barred list check to ensure they are not doing so. The activities are:

- healthcare
- personal care
- social work
- assistance with cash bills or shopping because a person needs that assistance because of their age, illness or disability
- assistance with the conduct of an adult's own affairs, including powers of attorney
- transport for adults in certain circumstances.

5.51 When used correctly, the Disclosure and Barring Service is able to effectively bar healthcare assistants/social care support workers. Action is underway to ensure that the NHS complies with its legal obligation to refer appropriate cases to the Scheme.

Reducing burdens

5.52 One of the key responsibilities for the leaders of organisations providing care is to ensure that their staff are not burdened by unnecessary bureaucracy.

5.53 The review of bureaucratic burden, *Challenging Bureaucracy*, led by the NHS Confederation, recommends three main ways to reduce unnecessary burden by understanding, reducing and actively policing the volume of requests from national bodies; reducing the amount of effort it takes providers to respond to information requests; and increasing the value derived from information that is collected. The Department of Health welcomes the review and will work with the Health and Social Care Information Centre to review all of the recommendations made in the NHS Confederation's report to determine how they can be taken forward.

5.54 In October 2013 the Secretary of State for Health wrote to NHS England, the Care Quality Commission, Monitor and the NHS Trust Development Authority asking each organisation to develop a detailed plan demonstrating how they will reduce the burden. In November 2013, all arm's length bodies signed a **Concordat for reducing the administrative burden arising from national requests for information**. The Concordat aims at ensuring that national requests for information are undertaken using a single transparent process and that there are significant year on year reductions in the cost and burden caused by requests for information to the front line.

5.55 NHS England has introduced a **Clinical Bureaucracy Index** to support Trusts in tracking how well they are using digital technology to reduce the burden of information collection on front line staff compared to their peers. The index will support Trusts to improve how they collect information to support good quality patient care in a way that is efficient and allows staff to focus on the delivery of compassionate care.

5.56 The role of the Health and Social Care Information Centre will be key to reducing burden. It is becoming the focal point for data collected at the national level and will become a 'gateway' for those seeking new data collections to help reduce the information 'burden' placed on providers.

5.57 In addition, the Health and Social Care Information Centre is leading a programme of work, which complements the work of the NHS Confederation outlined above, to help NHS Trusts to understand how they can take action to free up staff time to care by reducing bureaucracy. The first phase of the programme, which consisted of an audit of 16 acute Trusts to identify the cause of burden within those Trusts, was completed on 18 October 2013. The results of the audit are being analysed, and the Health and Social Care Information Centre will consider its findings at a national workshop this winter. The Health and Social Care Information Centre is also developing a self-assessment tool and toolkit so that Trusts can conduct their own audits on the wider sources and causes of burden on their staff.

Improving leadership

5.58 The failures at Mid Staffordshire NHS Foundation Trust included appalling failures of leadership at all levels of the organisation as well as in the wider system beyond the Trust.

5.59 Excellent leadership is critical to the delivery of safe and high-quality care so preventing such failures in the future means making excellent leadership the consistent norm at every level of the health system. To achieve this we know we need to deepen and enrich the leadership talent pool of the NHS, especially by:

- attracting and enabling new talent – including our best clinicians and brightest leaders from outside of the NHS – to take up leadership roles in the health system;
- supporting, developing and retaining the leadership capabilities of those already working in leadership roles in the NHS; and
- investing in a sustainable pipeline of leaders with the right values, behaviours and competencies at every level.

5.60 The new and recently established NHS Leadership Academy is playing a key role in taking these ambitions forward by putting in place for the first time a comprehensive and consistent national approach to leadership development in the NHS. This approach includes offering a range of leadership tools, models, expertise and accredited programmes to individuals, organisations and local academies – a crucial step in positively influencing the culture and values of the NHS from 'ward to board' that will directly lead to better care, experience and outcomes for patients.

Attracting top talent to senior leadership roles – a new NHS executive fast-track programme

5.61 The NHS needs to engage and harness the talent of clinicians who already work within it as well as being open to the new skills, ideas and leadership expertise that talented individuals who come from outside the NHS – but who share its values – can offer.

5.62 As such, the NHS Leadership Academy will initiate a new leadership programme to attract and fast–track the best NHS clinicians and brightest individuals from outside of the NHS to be the next generation of senior leaders of the health service.

5.63 The programme will be expertly designed and will reflect the lessons learned from previous initiatives that have aimed to engage clinicians and external talent in NHS leadership positions. More specifically, the programme will include:

- Tailored introduction to leadership in the NHS including intensive induction into the NHS for external entrants and rapid introduction to business management for clinical entrants.
- Rigorous executive education designed and delivered by a world-leading academic institution, complemented with placements in industry; the NHS Leadership Academy already works with institutions such as Harvard University on their existing core programmes and expects to be working with similar providers on this component of the programme.
- A significant period learning from the best by working in a substantive role with real responsibilities at a top NHS Trust under the mentorship of a leading NHS Chief Executive.
- Continued career management and support that will include coaching, mentoring and networking to prepare candidates for a successful entry to the NHS.

Developing leaders already in the NHS and investing in a talent pipeline for the future

5.64 The new NHS Executive Fast-Track programme will complement the significant work already underway by the NHS Leadership Academy to develop strong, inspiring leaders who are deeply connected to their patients, teams and communities and who are equipped to build a culture of purpose, innovation and compassion across the NHS.

5.65 This includes a suite of five accredited leadership development programmes that will see a range of NHS staff – including doctors, allied health professionals, nurses and midwives – develop the leadership skills, capabilities and behaviours to lead their teams, services and organisations at every tier of the NHS; and in doing so will also ensure a sustainable pipeline of leaders ready to meet the needs of patients, carers and communities for the future.

Integrated and system leadership

5.66 Integration across the NHS, public health and social care is a key means to achieving improvement in the quality of services and people's experience of them. An integrated system of leadership is required in order to implement an integrated system of care.

5.67 At a health system level, the NHS Leadership Academy also offers a range of programmes and expertise designed to raise the profile, performance and impact of health service leaders in provider, commissioning and other national organisations; promoting a core set of leadership standards and behaviours that all leaders should achieve.

5.68 A substantial programme of work to increase leadership capability is also underway in the social care sector including work to integrate health and social care. The National Skills Academy for Social Care has developed a Leadership Quality Framework which sets out the behaviours and competencies that should be demonstrated by good leaders. This Framework complements the existing NHS Leadership Framework. Together, these frameworks will support collaborative working as an essential element of successful leadership at all levels in the care and support and health sectors.

5.69 The System Leadership Steering Group which includes representatives from the Department of Health, the National Skills Academy for Social Care, the NHS Leadership Academy, public health and local government, is supporting a national integration programme consisting of eight pilots and 22 projects that are seeking to use a collaborative leadership approach to solving cross-cutting local issues such as alcohol abuse and raising levels of physical activity. The learning from these pilots and projects will inform future work on integrated leadership models.

5.70 All of this form part of a range of measures to support leaders throughout the system – including, but not confined to Boards – develop healthy cultures is where people at all levels are keen to take responsibility, and are willing to challenge and be challenged.

Leadership Academy programmes

NHS Leadership Academy Professional Development programmes

The NHS Leadership Academy Core Professional Development programmes consist of five developmental opportunities designed to support aspiring leaders at distinctive stages of progression in their health care career.

The Edward Jenner programme – Leadership Fundamentals

The Edward Jenner programme is designed by clinicians working on the frontline of care, it is highly practical and patient-focused, making it a valuable resource for all staff who want to build a more compassionate NHS. Alongside personal development, participants cover team working, ensuring patient safety, critical evaluation, improvement and innovation, service transformation and impact evaluation.

The Mary Seacole programme is for all NHS staff aspiring to be in a role that includes leading others.

Participants demonstrate their leadership skills and behaviour thorough leading change in their organisation. The programme aims to develop individuals who are willing to challenge what they see in practice. Learning includes understanding and improving the patient experience and patient safety, accountability, performance and improvement and human and social aspects of care. Robert Francis QC will record content specifically for the programme and the safer care aspects are aligned to the recommendation of the Berwick review.

The Elizabeth Garrett Anderson programme is for those who manage teams and services and are aspiring to a senior management role. The programme is very different from previous leadership development programmes as it focuses on the improvement of care to people served by the NHS and broader care system with a particular emphasis on behavioural and organisational impact.

The Nye Bevan programme is for experienced individuals who aspire to executive level strategic roles. The programme is designed to equip leaders to create and develop care environments centred on high quality, safe, compassionate care. The programme provides participants with an opportunity to examine their personal contribution to creating innovative, patient-centred services and reimagining an NHS fit for our next generation, providing them with the breadth of perspective on quality and safety to help prevent systemic failures.

Chapter 6 – Conclusion: Learning from Mid Staffordshire

My recommendations represent not the end but the beginning of a journey towards a healthier culture in the NHS in which good practice in one place is not considered to be a reason for ignoring poor practice somewhere else; where personal responsibility is not thought to be satisfied by a belief that someone else is taking care of it; where protecting and serving patients is the conscious purpose of everything everyone thinks about day in day out.

Robert Francis QC

6.1 This report makes clear the commitment of the Government, of national organisations, and also, and most importantly, of local health and care organisations and the people who work in them to forge a new culture centred on openness, trust and compassion out of the terrible and disturbing findings of the Inquiry conducted by Robert Francis QC.

6.2 A commitment to compassion and to safety and to putting the people who use services at the heart of those services must be a commitment to action, and it is truly heartening to see the work that is already being done up and down the country to make things right and to rebuild public trust in our NHS. The measures set out in this report will reinforce and support that local commitment to change.

6.3 Although nothing can ever take away the pain and loss of those who suffered at Mid Staffordshire NHS Foundation Trust and the anguish of their loved ones, we can, and must learn and apply the lessons that the Francis report has set out. We are determined, now and in the future, never to forget what happened, and to build a health and care system that puts people first.

6.4 The Francis report made clear that the disturbing events at Mid Staffordshire NHS Foundation Trust reflected wider systemic problems. This response has therefore taken a broad, system-wide approach to ensuring that cultural change takes root and has a real impact on care for patients in a way that redefines for the better the relationships between staff, patients and NHS organisations. The widespread commitment to the values and purpose of the NHS felt by staff and leaders of the NHS and by the country as a whole, along with the evidence of a willingness to change and improve that we are starting to see throughout the NHS should give us all the confidence that the challenges set out by Robert Francis QC can and will be met.

Annex A – Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings

In February 2013, the Secretary of State for Health asked Camilla Cavendish to lead an independent review into valuing and supporting healthcare assistants and support workers in the NHS and social care settings.

Camilla Cavendish was asked to:

- consider what can be done to ensure that all people using services are treated with care and compassion by healthcare and care assistants; and
- make recommendations about the recruitment, training and development, management and support of those staff, who do a challenging and vital job.

The Review focused as much as possible on the frontline of care, talking to staff in hospitals and care homes, meeting with domiciliary care workers, healthcare assistants, personal assistants, nurses and registered managers. It also sought the views of some organisations involved in health and social care. The review's report[xxiii] was published on 10 July 2013.

REVIEW FINDINGS

The main findings of the Review were as follows:

- What Cavendish termed as 'a disconnected landscape' – that the NHS operates in silos, and that 'social care is seen as a distant land occupied by a different tribe'.
- Healthcare assistants are a critical, strategic resource, yet they have no compulsory or consistent training, and a profusion of job titles. This confuses patients – and makes life difficult for nurses, who are not always sure which tasks they can safely delegate.
- Some healthcare assistants are now performing tasks delegated to them that used to be the preserve of nurses, even doctors. Yet their pay is well below a newly qualified nurse. This leaves many feeling undervalued and overlooked.
- Social care support workers are also increasingly taking on more challenging tasks, having to look after more frail elderly people. Yet their training is hugely variable. Some employers are not meeting their basic duty to ensure their staff are competent.
- Average pay of social care support workers is below a healthcare assistant's starting salary in the NHS and there are high annual turnover rates across the social care workforce.

WHAT THE REVIEW RECOMMENDED

The Review made a number of recommendations on how the training and support of the over 1.3 million healthcare assistants and social care support workers could be improved. One of the main recommendations was that all healthcare assistants and social care support workers should undergo the same basic training, based on the best practice that already exists in the system, and must get a standard 'certificate of fundamental care' before they can care for people unsupervised.

It also recommended, amongst other measures, that a system of quality assurance for training be developed. Cavendish further proposed that advice to employers be commissioned, so that they can more effectively identify and remove staff that are performing unsatisfactorily.

RESPONDING TO THE REVIEW AND NEXT STEPS

The Cavendish Review highlighted many examples of good training and support in both health and care settings and advocated learning from the best but also identified problems with consistency and quality across both sector. The Government broadly accepts the findings of the review and is committed to drive forward implementation in the direction of travel that she has proposed, ensuring healthcare assistants and social care support workers receive high quality and consistent training and support they need to do their jobs. A full update on progress in implementing the Review's recommendations will be set out in the next system-wide update on the response to Francis.

RECRUITMENT, TRAINING AND EDUCATION

The Government has accepted Cavendish's recommendation for developing a Care Certificate

On 7 October 2013, Earl Howe tabled an amendment to the Care Bill updating the provisions in the Health and Social Care Act that would enable regulations to be made to specify a body that would set training standards in respect of healthcare assistants and social care support workers.

On 21 October 2013, the Government asked Health Education England to work with sector skills councils, other delivery partners and health and care providers to develop a Care Certificate.

The introduction of the Care Certificate supports our wide policy objectives of ensuring that healthcare assistants and social care support workers receive the high quality and consistent training and support they need to do their jobs and will focus in particular on induction in the fundamentals of caring. This should ensure that they understand the skills required and demonstrate the behaviours needed to deliver compassionate care. The Care Certificate will be evidence that the worker has received training and has skills which are fully in line with the standards set in line with the regulations referred to above. This will be key to ensuring that those standards are applied consistently throughout the health and social care sectors.

Under its current Mandate, Health Education England is already working with key partners, including NHS Employers, on value based recruitment around values and behaviours. It is also contributing to programme of work for the Chief Nursing Officers' national strategy for nursing and midwifery, *Compassion in Practice*. A Value based recruitment tool for Social Care was launched in July 2013, and will be piloted for 12 months.

Similarly, the National Skills Academy for Social Care, working in partnership with Skills for Care and Macintyre, employers and staff have developed a values based-recruitment toolkit for social care bringing together a range of directly targeted, easy to use tools that employers, especially small and medium-sized enterprises and micro employers can use when recruiting staff to assess candidates for appropriate social care values, as evidenced through their behaviours. The toolkit was launched by the Minister for Care Services in July 2013 and will be piloted for 12 months. The National Skills Academy will be evaluating the model to understand the take-up of approach across the sector, its usefulness and impact. The Academy is planning an interim report on the model in early spring 2014 and a full evaluation will be available in early autumn 2014.

MAKING CARING A CAREER

Health Education England is working on the delivery of its Mandate around widening participation and has initiatives to encourage a wider section of the community and existing care support workers, amongst others, into professional training to become nurses or other healthcare professionals. In addition, Health Education England is developing plans to further increase the number of healthcare apprentices, and is also exploring funding arrangements, through local partnership working, to develop and make best use of the talents of the existing NHS workforce.

Furthermore, Health Education England are working with employers to improve capability of the care assistant workforce and build on the career pathway work that Skills for Care and Skills for Health have in place for health and other social degrees, to ensure that different programmes are transferable and comparable and support progression into a variety of healthcare professional and social care degree programmes, including developing new bridging programmes.

EFFECTIVE LEADERSHIP, SUPERVISION AND SUPPORT FOR HEALTH AND SOCIAL CARE SUPPORT WORKERS

The Chief Nursing Officer is leading a piece of work with a range of stakeholders around developing proposals on the use of the term 'Nursing assistant' recognising the title does not apply to all healthcare assistant groups. Further consideration needs to be given on the wider implications for use of the title itself relating to the Care Certificate.

The Chief Nursing Officer has also agreed to lead the recommendation around empowering Directors of Nursing to take greater board level responsibility for the recruitment, training and management of healthcare assistants. The Chief Nursing Officer's intention is to link this work

with the *Compassion in practice* action area 4 on leadership and action area 5, (right staff with right skills in the right place).

The Government has commissioned the Professional Standards Authority for Health and Social Care for advice on how employers can be more effective in managing the dismissal on unsatisfactory staff, the legal framework around this, and the relationship with referrals to professional regulators. It will then need to take stock of the advice and consider how it can work with the Professional Standards Authority to make this accessible to employers as a second phase of the work.

Skills for Health and Skills for Care published a code of conduct for support workers in March 2013 and will review the code to ensure the language is readily understood and that there is synergy with the social care commitment for adult social care workers.

In addition, the Department of Health has developed a Social Care Commitment, which was launched in September 2013. This is the sector's promise to provide people who need care and support with safe, high quality services. In order to make commitments, employers, care workers and carers sign up to statements that focus on values and behaviours and pledge to complete tasks that support the statements.

The commitment will have a key role to play in helping to improve public trust in the care sector. From December 2013, once a Care Quality Commission registered care provider has signed up to the commitment, the public will be able to see this on their NHS Choices profile. At the same time, the public will be able to search the social care commitment website and see which organisations have signed up, including any non-Care Quality Commission registered providers.

The Department will monitor the impact of the commitment before considering imposing any formal code of conduct.

TIME TO CARE

The Chief Nursing Officer has agreed to lead the work with key stakeholders on the impact of 12 hour shifts on Healthcare Assistants recognising this would not apply to social care support workers. Skills for Care will work in parallel with NHS England and look at the impact of 12 hour shifts on the social care sector and we will build this into the Skills for Care business plan for 2014-15.

We agree we should be moving towards better commissioning based on outcomes rather than activity, or for slots of time. And we want to encourage local authorities to do so to help to deliver better quality care for people who need care and support.

We agree that designating 15 minutes to care can be an unrealistic time to complete tasks during a home care appointment in most instances.

The Government amended the Care Bill so there is an explicit requirement for local authorities to consider people's wellbeing when commissioning services. This is planned to take effect from April 2015, subject to Parliamentary approval. The Government is also gathering ideas through the 'Home Innovation Challenge' of how to make homecare better. Later in the autumn it will set out how this will continue to make a different to future homecare.

The Department of Health will also be working with the Association of Directors of Adult Social Services to develop a set of 'commissioning standards' to support and drive continuous sector-led improvements across the country. We expect these to be developed by April 2014 and then to be used when they have been tested for effectiveness.

We agree with the concerns that Camilla Cavendish raises about whether some employers not paying for travel time between home care visits is leading to some workers receiving less than the national minimum wage. Payment of travel time is a requirement of regulation 15(2b) of the National Minimum Wage Regulations 1999. The Department for Business Innovation and Skills provide guidance based on the regulations on the gov.uk website which sets out what counts as working time when calculating national minimum wage. This guidance says that for all types of work, working time includes 'travelling from one work assignment to another.' Non-compliance with the law is unacceptable.

The Government is taking action to address this and to improve compliance with national minimum wage legislation including Her Majesty's Revenue and Custom's targeted enforcement activity on non-compliance in the care sector. Alongside this enforcement activity and we will develop statutory guidance for local authorities which refers to employment law and to the Department for Business, Innovation and Skills guidance on payment of travel time**,** to assure themselves that the care companies they contract with comply with National Minimum Wage regulations.

Annex B – Review into the quality and safety of care at 14 NHS hospital Trusts in England

In February 2013, the Prime Minister and the Secretary of State for Health asked Professor Sir Bruce Keogh to lead a rapid, in-depth investigation into the quality of care at 14 trusts that over the last two years were consistent outliers in mortality data.

Sir Bruce was asked to:

- Determine whether there are any sustained failings in the quality of care and treatment being provided to patients at these trusts.
- Identify:
  - i) whether existing action by these trusts to improve quality is adequate and whether any additional steps should be taken;
  - ii) any additional external support that should be made available to these trusts to help them improve; and
  - iii) any areas that may require regulatory action in order to protect patients.

The review heard directly from around 750 people at open 'listening' events and had over 1200 submissions from the public through the website, by phone, or by post. In addition, the review teams conducted planned and unannounced site visits to the trusts, spoke to staff and patients based on evidence they had gathered. Where areas of serious concern were identified, these were flagged up for immediate action, to protect patients. The review's report[xxiv] was published on 16 July 2013.

REVIEW FINDINGS

The review teams found pockets of excellent practice in all 14 of the trusts reviewed, but also found significant scope for improvement, with each needing to address an urgent set of actions in order to raise standards of care.

11 of the 14 trusts (including six Foundation Trusts) were placed into special measures, requiring expert support to rapidly improve their performance. The trusts are being supported by a variety of organisations, including high performing NHS trusts, and Monitor and the NHS Trust Development Authority. Monitor and the Trust Development Authority are regularly assessing what further support can be provided to help these trusts make the required improvements rapidly. The Department updated on progress in turning around the performance of these trusts on 19 September 2013[xxv] and will continue to provide regular updates. All of the 14 trusts will be re-inspected over the next 12 months.

WHAT THE REVIEW RECOMMENDED

The Review described eight high-level ambitions for the system to work towards, to use information effectively, and to drive improvements in the safety and quality of care in hospitals. For each of these ambitions Sir Bruce gave some practical actions that different parts of the system should be undertaking to help realise the ambitions.

The ambitions are:

1. We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.

2. The Boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level.

3. Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others.

4. Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in inspections.

5. No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past.

6. Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards.

7. Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.

8. All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.

RESPONDING TO THE REVIEW AND NEXT STEPS

The Department of Health welcomes the findings of the Review and will work with organisations across the system towards meeting all the ambitions to improve the quality of healthcare. On 19 September 2013 the relevant organisations reported on progress in improving quality in the Trusts that were placed into special measures.

The ambitions apply right across the healthcare system, and it is important that all providers of care take on board the lessons of the Keogh Review. Boards of Trusts must be open and transparent about the quality of care and ensure they are aware of quality problems within

their Trusts, such as the ones picked up by the Keogh Review. Trusts that take on board the lessons of the review, take action in areas where improvement is needed, and work towards improving the quality of care they offer, can expect support from a range of stakeholders.

Following the Keogh Review, work has already begun on the new inspections regime. The Care Quality Commission will monitor information and evidence to anticipate, identify and respond more quickly to acute hospitals that are failing, or are at risk of failing. The new Chief Inspector of Hospitals, Professor Sir Mike Richards, has built upon the methodology of the review process in the inspection regime, to ensure that robust information and multidisciplinary inspection plays a significant part in assessing the culture and quality of care in hospitals. Along with a new surveillance system to support the new regime and the Quality Surveillance Groups, this will ensure information from across the system is brought together. The Care Quality Commission will inspect all hospitals and where it finds poor care, with relevant partners it will take action. The Care Quality Commission has begun its new in-depth, expert-led hospital inspections which will also be used on the 14 trusts in the review when they are re-inspected within 12 months.

KEY ACTIONS

The Government has commissioned a study looking into the relation between mortality ratios and avoidable deaths through case note reviews. From this study a new national indicator on avoidable deaths will be created. This robust overarching measure of the safety of healthcare services will also directly measure problems in care and the nature of such problems to allow Trusts to develop actions and disseminate learning to prevent recurrence.

The need to improve the access to quality data and the competence of leadership to analyse this data has been recognised: Healthwatch England is developing a strategy to ensure local healthwatches have access to such data; the NHS Trust Development Agency and Monitor are working to improve quality governance and leadership skills in the use of quality data. Over time there is an ambition that NHS England, Monitor, the Care Quality Commission and the NHS Trust Development Agency will develop a common dataset for quality for use by commissioners and regulators. The Care Quality Commission is currently developing a surveillance system to support their new inspection regime. The new Quality Surveillance Groups will also help bring together the wide variety of information different organisations hold with new guidance's being developed to share good practice by the Quality Surveillance Groups as they continue to develop.

Local healthwatches will be forging relationships with providers, the NHS Trust Development Agency and Monitor are preparing guidance to help support non-executive managers and governors bring a patient voice to boards, and NHS England will also work to support and train patients and carers to take part in NHS governance structures. NHS England has published new guidance to support commissioners on participation in healthcare. NHS Trust Development Agency guidance requires boards to engage with patient feedback, and the NHS Trust Development Agency is working with NHS trusts to support the sharing of good practice.

Work is progressing in the creation of academic health science networks to ensure that trusts are operating with the latest clinical knowledge. The 14 trusts in the review are a priority for becoming members. Further work is underway to assess how to facilitate providers in releasing their staff to support improvements across the NHS through participations in inspections, peer review, and training, leading to a culture of continual improvement and the sharing of innovation and learning across the wider NHS.

The National Quality Board and the Chief Nursing Officer are publishing new guidance on safe staffing levels in hospitals and National Institute for Health and Care Excellence has been commissioned to provide authoritative independent advice on evidence based tools to ensure the right levels of staff on every shift on every ward on every day in the NHS.

Health Education England is now providing feedback from trainee doctors and student nurses to the new Chief Inspector of Hospitals for the new inspections. When patient safety concerns are picked up by junior doctors these will be passed through to management teams. The importance of harnessing junior doctors to improve quality will continue to be promoted by the national medical director through support for policies such as the Clinical Fellows Scheme.

Annex C – Improving the safety of patients in England

In February 2013, the Prime Minister asked Professor Donald Berwick to conduct a review of safety and 'to make zero harm a reality in our NHS'.

Professor Berwick chaired the National Advisory Group on the Safety of England of Patients to conduct an independent review, which was asked to.

- reflect on the findings of the Francis Inquiry's final report, in relation to the quality of care and safety of patients in the NHS
- form a set of principles for, and approach to implementation of, a whole-system approach to achieving harm-free care throughout the NHS in England.

The Review appointed some Senior Advisors, upon whom the Committee could call for information and suggestions.

Seven working parties examined specific themes, and advisors and others made comments by invitation at Committee meetings. The final report[xxvi] was published on 6 August 2013.

REVIEW FINDINGS

The review paid tribute to the NHS as, *a world-leading example of commitment to health and health care as a human right*; the NHS is neither more or less safe than other care systems; and the vast majority of staff that work and support the NHS are committed to the values on which it was established.

The review was explicit that the culture described of Mid Staffordshire NHS Foundation Trust reflects a wider societal culture. The focus of blame should not be laid on NHS staff and that we should look at the conditions and wider context in which staff work. The Review pointed to the warning signals that were not heeded in Mid Staffordshire Healthcare NHS Foundation Trust; the fact that targets and finance were overriding considerations; and that concealment and gaming of data and goals were symptomatic of a misappropriation of priorities.

WHAT THE REVIEW RECOMMENDED

The Review made a range of recommendations in relation to leadership, patient and public involvement, training, measurement and transparency, staff, structure and regulation and enforcement. It also set as an overarching goal for the NHS that it should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.

RESPONDING TO THE REVIEW AND NEXT STEPS

The Government has welcomed the report and accepts all its overarching recommendations. It is also recognises that while the lessons from this review focus on the NHS, its key findings on culture and learning are equally relevant to social care. Working with its partners, the Department of Health is considering how the recommendations will now be implemented.

Key actions in response to the review's recommendations:

- The review called for the Government and NHS leaders to state the primacy of safety and quality as the aims of the NHS. The Government has restated this commitment in its further response to Francis.
- The Department of Health has agreed with the nursing and medical Royal Colleges and clinical leaders that every hospital patient should have the name of the consultant and nurse responsible for their care above their beds. The Government also intends to introduce a named accountable clinician for people receiving care outside hospitals, starting with vulnerable older people. Clinical commissioning groups will be commissioning support for patients' participation and decisions in relation to their own care and patient and public involvement will be at the heart of commissioning, with at least two lay members on commissioning groups governing bodies. At a national level, the Care Quality Commission is now involving patients in its inspections to inform its ratings of hospitals. Trust Chief Executives and Boards will be expected to take personal responsibility for complaints, for example by signing off letters and through an update at each board meeting. Detailed information on complaints and the lessons learned will be published quarterly.
- The NHS Leadership Academy and Health Education England will be investing in education and training programmes to ensure that safety is embedded in leadership programmes and other post graduate training programmes for professionals.
- NHS England is working with NHS Improving Quality to develop proposals for the establishment of a network of Patient Safety Collaboratives across England. The aim of the Collaboratives is to create a comprehensive, effective, and sustainable improvement system that will deliver a culture of continual learning and improvement in patient safety across the country over the next five years. The design, support and recruitment of participating organisations is planned to be delivered by spring 2014. The programme will also include establishing a Patient Safety Improvement Fellowship scheme to develop 5,000 Fellows within a national faculty within five years.
- NHS England and the Care Quality Commission are committed to working together to develop a shared and agreed approach to measuring safety in the NHS, both for regulatory and improvement purposes. The organisations are working to develop a set of patient safety measures that are best suited for use by the Care Quality Commission in their surveillance model, and NHS England is providing patient safety expertise on how patient safety data might be used for surveillance and inspection.
- NHS England will be publishing never events quarterly before the end of 2013 and monthly by April 2014, and is exploring ways to make safety thermometer data more accessible to

the public. NHS England is leading on work to develop a single and agreed methodology for retrospective case note reviews undertaken by Trusts.

- There are new arrangements for inspection and regulation in terms of quality and safety and a commitment by system and professional regulators to cooperate in the sharing of information and concerns.
- The review confirmed the Government's plans to introduce a new statutory duty of candour on providers. **We are working with the professional regulators to strengthen the references to candour in professional regulation.** The Government will also seek to introduce a new criminal sanction that covers wilful neglect designed for those guilty of the most extreme types of poor care.

Annex D – A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture

BACKGROUND

In February 2013, the Secretary of State for Health announced that he had asked the Rt Hon Ann Clwyd, MP for Cynon Valley, and Professor Tricia Hart, Chief Executive of South Tees Hospitals NHS Foundation Trust, to carry out an independent review of best practice on complaints handling to ensure that when problems are raised, they are heard, addressed and acted upon, and seen as vital information for improvement, rather than irritations to be managed defensively.

Ann Clwyd and Tricia Hart were asked to:

- Consider how patients, their carers and families are listened to, and how what they say is acted upon
- Identify key components of good practice and how to improve its adoption
- How complainants can be supported more effectively during the complaints process
- Review the role of Trusts' boards in developing a culture that takes complaints seriously.

The review team engaged with patients and their carers and representatives, staff and managers to understand their experience of the way concerns and complaints are managed and acted on. In all over 2500 letters and emails were received from patients, relatives, friends and carers. The review team visited nine NHS hospitals and one hospice, meeting complaints managers, frontline staff and board members.

REVIEW FINDINGS

The Review's key findings are:

- Vulnerable people find the complaints system complicated and hard to navigate
- There is a low level of public awareness of the NHS Complaints Advocacy Service
- People are reluctant to complain and staff can be defensive and reluctant to listen to or address concerns
- Organisations do not always deliver their legislative responsibilities on complaints handling
- There is a need for quality, trained staff to deal with complaints effectively and appropriately.

WHAT THE REVIEW RECOMMENDED

The Review's key recommendations are as follows:

- Every Chief Executive should take personal responsibility for the complaints procedure, including signing off letters responding to complaints, particularly when they relate to serious care failings.
- There should be Board-led scrutiny of complaints. All Boards and Chief Executives should receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action. These reports should be available to the Chief Inspector of Hospitals.
- There should be a new duty on all Trusts to publicise an annual complaints' report, in plain English, which should state what complaints have been made and what changes have taken place.
- Trusts should provide patients with a way of feeding back comments and concerns about their care on the ward including simple steps such as putting pen and paper by the bedside and making sure patients know who to speak to if they have a concern – it could be a nurse or a doctor, or a volunteer on the ward to help people.
- Patient and advice liaison services should be re-branded and reviewed so it is clearer what the service offers to patients and it should be adequately resourced in every hospital.
- The Care Quality Commission should include complaints in their hospital inspection process and analyse evidence about what the Trust has done to learn from their mistakes.
- Trusts should actively encourage both positive and negative feedback about their services. Complaints should be seen as essential and helpful information and welcomed as necessary for continuous service improvement.

RESPONDING TO THE REVIEW AND NEXT STEPS

The Government welcomes and accepts the spirit of the review and the principles behind the recommendations, although many are for action at individual Trust level. In line with the recommendations made by Rt Hon Ann Clwyd and Tricia Hart and the Francis Inquiry, the Government wants to see the following changes in the complaints system:

LOCAL ACTION

- Trust Chief Executives and Boards should promote a culture of openness and encouraging feedback and welcoming complaints. Staff must be trained and encouraged to seek feedback, and act on it.
- The Government wants to see every Trust make clear to every patient from their first encounter with the hospital:
  - how they can complain to the hospital when things go wrong;

  - who they can turn to for independent local support if they want and where to contact them;
  - that they retain the right to complain to the Parliamentary Health Service Ombudsman if they remain dissatisfied and how to contact her; and
  - details of how to contact their local Healthwatch, who, in some areas may provide advocacy services, but in all areas can provide general advice and information on health and care issues.
- A sign in every ward and clinical setting would be a simple means of achieving this and the Department will be discussing with Healthwatch England, Care Quality Commission and NHS England the best means of ensuring this becomes standard practice in all NHS hospitals in England. We would expect these posters to set out how to complain about a hospital, how to seek support from their local Healthwatch and how to refer their complaint to the Ombudsman.
- We want to **see patient advice and liaison services well-sign posted, funded and staffed** in every hospital so patients can go and share a concern with someone else in the hospital if they do not feel confident talking to their nurse or doctor on the ward.
- **We want to see Trust Chief Executives and Boards taking personal responsibility for complaints handling**. This includes signing-off letters to patients, ensuring every patient is offered a conversation at the start of the complaints process, and that they are clear that if they are not happy with the way the complaint has been handled they can get an independent view from the Health Service Ombudsman.
- **We want to see Chief Executives ensuring there is greater clinical involvement in handling complaints**. This could be through offering patients a conversation with the nurse or doctor involved in the complaint, if that is something the patient wants.
- **We also want to see Directors with responsibility for patient safety being required to give a detailed update on complaints at each Board meeting** and we will work with NHS England to determine the most effective mechanism through which to achieve this.
- **We want Boards to see regular data about complaints which means** the 'narrative and not just the numbers', so they can identify themes and recurring problems, and take action. All Trusts, not just the good ones, should see complaints as an opportunity to learn and improve the care they provide.
- **Detailed information on complaints and the lessons learned will be published quarterly.** This will include the number of complaints received as a percentage of patient interventions; the number of complaints the hospital has been informed have subsequently been referred to the Ombudsman and the lessons learned and improvements made as a result of complaints.
- We strongly agree that **complaints amounting to a serious or untoward incident warrant independent local investigation**. We want to see all hospitals using their statutory powers to offer this to patients.

LOCAL ACTION – THROUGH THE LOCAL HEALTHWATCH NETWORK

- It is important that local Healthwatch, as the patient and public champion for health and care services, should be as strong and effective as possible so that it can speak up for patients and provided independent support on complaints.
- **We support Healthwatch England in their plans to coordinate a consumer-facing complaints campaign with their partners.** This will help ensure there is better quality information for patients about how to raise a concern and the standards they should expect if they make a complaint.
- We agree that there is an important role for local Healthwatch to play in scrutinising complaints, and complaints handling locally. **We want to see local HealthWatch scrutinising complaints data across Trusts in an area to spot themes** and recurring issues in an area with their unique local perspective. Whilst it is important that Trusts respect patient confidentiality when releasing information on complaints to outside organisations but, subject to this caveat, we strongly consider that Trusts should seek to provide the complaints data that are requested by local Healthwatch and Overview and Scrutiny Committees.
- We agree that patients should be offered independent advocacy and support as they go through the complaints process, particularly if the case is complex and about a serious care failing. Local authorities currently commission advocacy services **but we see a role here for HealthWatch England, working with Department of Health and others to help set the standards for good advocacy.** The Department of Health will begin an evaluation of the current arrangements for commissioning NHS complaints advocacy services in 2014.

NATIONAL ACTION

To support these improvements the Government will take the following actions:

- The Department of Health agrees it is appropriate to review the patient and advice liaison services service, and will undertake to begin that review in 2014.
- The Department agrees that complaints should be a key part of the **new Chief Inspector of Hospital's inspections and welcome this commitment.** The Chief Inspector will look at how well a Trust deals with complaints and this will involve looking at a sample of real life complaints and what action was taken, as well as talking to patients.
- **The Chief Inspector has also agreed to publish a thematic report in a year's time on themes and trends in complaints data** emerging during his hospital inspections across England, which we welcome.
- The Parliamentary and Health Service Ombudsman and Healthwatch England, working with the Department of Health, will develop a patient-led vision and expectations for complaints handling in the NHS. The Parliamentary and Health Service Ombudsman, Healthwatch England and the Department of Health will work with the Patients Association,

patients, regulators, commissioners and providers to develop universal expectations for complaints handling. These will be used across the NHS to drive improvements in patient satisfaction with complaint handling. The vision and expectations will inform:

  - Patients about what to expect when they make a complaint about NHS services
  - The work of the Healthwatch network in challenging local providers to improve their practices
  - Providers and commissioning bodies about what they can do to use patient concerns and complaints to improve services and how they can measure their own progress
  - Regulatory assessment of hospital complaint handling
  - The Parliamentary and Health Service Ombudsman investigation of complaints about NHS services brought to them by patients and their families.

- The Parliamentary and Health Service Ombudsman is working with the Care Quality Commission on what insight she can provide on complaints she has investigated to inform hospital inspections.
- The Government will explore with NHS England and other key partners the introduction of **a regular and standard way of surveying people who have made a complaint** to find out whether they were satisfied with the way it was handled, and to enable comparison across hospitals.
- The Department of Health will work with the Health and Social Care Information Centre to **put complaints data into the existing NHS electronic data collection system, better enabling comparison between hospitals**.
- **The Chief Inspector and Care Quality Commission will require regular reporting of complaints from all providers to inform its surveillance and risk profiling regime.** Care Quality Commission will naturally be particularly interested in complaints concerning death, serious injury or 'near misses' but will also want to harness information about other aspects of patient experience and concern which would be indicative of trust culture and performance**. Care Quality Commission will be discussing with Monitor, Trust Development Authority and providers a proportionate and cost-effective means of doing so.**
- **The Department of Health will work with Action against Medical Accidents and NHS England to clarify that a threat of future litigation should not delay the handling of a complaint.**

THE OMBUDSMAN

- The Parliamentary and Health Service Ombudsman is independent of the NHS and Government, and provides an important service to patients, giving them somewhere to turn if they feel their complaint is not handled properly locally. **The Department welcomes the Ombudsman's ambition to significantly increase the number of cases she takes on**, and her valuable role helping the health system to interrogate and learn lessons from complaints.

Annex E – Burdens review

BACKGROUND

In February 2013 the Secretary of State for Health announced that the NHS Confederation would undertake a review of bureaucratic burden in the NHS. The primary focus of the Review was intended to support healthcare staff spend as much time as possible delivering patient care by being alleviated of the unnecessary burden imposed on NHS providers of care from national bodies.

This report built on the Government's[xxvii, xxviii] published by the NHS Confederation and the Independent Healthcare Advisory Service.

The final report, *Challenging Bureaucracy* was published on 19 November 2013.

REVIEW FINDINGS

The review noted that much of what the NHS collects is essential to assuring and improving patient care enables clinicians to better understand the care they provide. It also concluded there was a consensus among clinicians, managers and national bodies that reporting requirements were increasing and that, where this forms part of a better understanding of the quality of care, was a positive step.

Of the total burden placed on the NHS, it was found the majority derived from the trusts themselves (45%), with local/commissioning bodies and national bodies accounting for approximately a quarter of the total burden each. The burden, from national reporting, was found to be significantly higher that had been previously thought at an estimated £300–£500 million annually.

While the review found that progress had already been made in reducing the volume of unnecessary burden from national bodies, it also noted that more could be done.

WHAT THE REVIEW RECOMMENDED

The review made 30 recommendations that together focussed on ways in which the burden on NHS providers could be reduced by either: understanding, reducing where possible, and policing the volume of requests from national bodies; reducing the amount and variability in the effort it takes providers to respond to information requests; and increasing the value that is derived from the information collected.

RESPONDING TO THE REVIEW AND NEXT STEPS

The Government has welcomed the report and accepts its recommendations. The Department of Health, working with its partners, is now considering how the recommendations could be implemented. In some cases, work to take them forward has already started either as a result of existing programmes of work, such as the implementation[xxix] or as part of the Government's response to the Inquiry.

The central role of the Health and Social Care Information Centre will be key to many of the recommendations and, in particular, its function increasingly as the focal point for data collected at a national level and the 'gateway' for those seeking new data collections. The Department of Health will work closely with the Health and Social Care Information Centre in determining the best way to take these recommendations forward appropriately.

NHS England has introduced a Clinical Bureaucracy Index to support trusts track how well they are using digital technology to reduce the burden of information collection on front line staff compared to their peers. This will underpin our approach to meeting recommendation 20.

Additionally, the Department of Health and every arm's length body signed a Concordat for reducing the administrative burden arising from national requests for information. The concordat aims at ensuring that national requests for information are undertaken using a single transparent process and that there are significant year on year reductions in the cost and burden caused by requests for information to the front line. This will help us to meet recommendation 5 and to start reducing the burden which is the basis of recommendation 11.

Annex F – Children and Young People's Health Outcomes Forum's report for the Secretary of State for Health

BACKGROUND

In March 2013, Professor Ian Lewis (Medical Director, Alder Hey Children's Hospital) and Christine Lenehan (Director, Council for Disabled Children) wrote, as the co-chairs of the Children and Young People's Health Outcomes Forum, to the Secretary of State to offer the Forum's assistance in addressing the broad issues, particularly of culture change, raised in the report by Robert Francis QC as they relate to children and young people. The Secretary of State accepted this offer.

A small subgroup of the Forum led the development of the response, which was also informed by the views of children and young people, which the National Children's Bureau gathered on the Forum's behalf over the summer.

The co-chairs submitted the Forum's final response through him to the Secretary of State on 23 October 2013.

REVIEW FINDINGS

In its response to the Inquiry report, and informed by the subsequent reports by Professor Don Berwick and Sir Bruce Keogh, the Forum focuses on a number of key themes:

- a culture that supports a child and young person focused approach, with the involvement of children and young people in their own care
- leadership at all levels to advocate for, and support, the needs of children and young people
- workforce capacity and competence, and
- specific issues of patient safety that are most relevant to children and young people.

The Forum concluded that, although the Inquiry response focused primarily on NHS hospitals, the core messages are applicable to all staff and organisations working across the health and care system, whatever the setting. The Forum called for a universal children and young people friendly culture.

WHAT THE REVIEW RECOMMENDED

The Forum made a series of recommendations in relation to the NHS Constitution, leadership, inclusion of children and young people in patient and public involvement, training, transparency, safety and outcome indicators. It also set as an overarching goal for the NHS that it should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.

RESPONDING TO THE REVIEW AND NEXT STEPS

The Forum's response to the Inquiry includes new recommendations aimed variously at the Department of Health, NHS England, Health Education England, Healthwatch and local service commissioners and providers, that will be considered carefully by each in the coming weeks.

The Department of Health welcomes the Forum's work in this area, and intends for its recommendations to help inform our work as we move forward in light of the Public Inquiry's conclusions. For example:

- NHS England are supportive of the proposal that they should develop a roll-out of programmes using improvement methodology through the Strategic Clinical Networks (including that for Maternity and Childrens Services) to address each of the main safety areas for children and young people. The National Clinical Director for Childrens services and the Patient Safety team will take this work forward.
- The refresh of the Governments Mandate to Health Education England will take into account the Forums recommendations when reviewing Health Education England's objectives aimed at helping give children the best start in life.
- The review of complaints handling has made several recommendations to improve the way complaints in NHS hospitals are dealt with (see annex D). As the complaints regulations cover all users of NHS-funded care, it will be important that children and young peoples needs are furthered by the implementation of the reviews recommendations.

The Forum will continue to further develop the issues it has raised in its report, including those around culture of care, in its annual report in February 2014. It will continue to work closely with ministers and wider system partners to build on this work, to improve health outcomes for children and young people.

Annex G – The NHS – Key Players

The NHS – Key Players	Roles and Responsibilities in the System
Patients	Patients have a right to high quality, safe and effective care. They should be supported to promote and manage their own health by being enabled to make informed decisions.
Staff	Staff in the NHS have a duty to provide safe, high quality, compassionate care. They will put safe and compassionate care at the heart of everything they do.
Provider organisations	All providers of NHS services – whether from the public, voluntary or private sector- have a responsibility to enable their staff to deliver high quality, compassionate care for patients. They will ensure quality outcomes, drive improvement and support a culture of safety, learning and transparency.
Commissioning organisations	Clinical commissioning groups are responsible for commissioning healthcare services. They support the services they commission to provide safe, effective and compassionate care. They will share information and take action where fundamental standards of care are not met.
NHS England	NHS England empowers and supports clinical commissioning at every level of the NHS. It helps commissioners to make genuinely informed decisions, spend taxpayers' money wisely and provide high quality services. NHS England also directly commissions a range of services, including primary care, specialised services, certain public health services and services for the military and people in places of detention.
Care Quality Commission	The Care Quality Commission is the independent inspector of all health and social care services in England. It rates organisations using an expert inspection team and has the authority to ensure problems are addressed.

The NHS – Key Players	Roles and Responsibilities in the System
Monitor	Monitor is the sector regulator for health services in England. Monitor licenses providers of NHS services and enforces compliance where the services of foundation trusts are failing to provide good quality care for patients. Monitor also sets prices for services, tackles anti-competitive practices and helps commissioners protect essential local services if providers get into serious difficulty.
NHS Trust Development Authority	The NHS Trust Development Authority ensures that high quality, sustainable services are delivered by all NHS trusts. It does this by overseeing the performance of NHS trusts, and providing them with leadership, support and development. Thereby, helping NHS trusts to prepare for achieving Foundation Trust status or another sustainable organisational form.
National Institute for Health and Care Excellence	National Institute for Health and Care Excellence is responsible for defining and maintaining national clinical guidelines to secure consistent, high quality, evidence based care for NHS patients in England.
Health Education England	Health Education England is responsible for ensuring there is an effective system in place to support the education, training and development of staff. They will promote recruitment for both skills and values, ensuring staff are both competent and compassionate.
Professional regulators	The professional regulators regulate and support improvement in standards for health and care professionals. They also set and assure quality standards.
Royal Colleges	The Royal Colleges are responsible for providing leadership to the medical professions. They define standards of care and medical education and will share information with other relevant bodies to ensure vital insights are not missed.
Department of Health	The Department of Health is the system steward. It is responsible for ensuring all key organisations work together effectively in the interest of patients.

Endnotes

i. For the many inspirational pledges made as part of NHS Change Day, see http://www.changemodel.nhs.uk/pg/groups/33183/NHS+Change+Day/27?community=NHS+Change+Day

ii. Michael West, Richard Baker, Jeremy Dawson, Mary Dixon Woods, Richard Lilford, Graham Martin, Lorna McKee, Madeleine Murtagh, Patricia Wilkie, Quality and Safety in the NHS: Evaluating Progress, Problems and Promise, 2013, http://www.lums.lancs.ac.uk/files/quality-safety-nhs-e.pdf

iii. Transforming participation in health and care. 'The NHS belongs to us all', September 2013, http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

iv. See *Local Healthwatch outcomes and impact development tool* http://www.local.gov.uk/publications/-/journal_content/56/10180/5436843/PUBLICATION

v. See Alys Cole-King and Paul Gilbert, 'Compassionate care: the theory and the reality', *Journal of holistic healthcare,* December 2011 http://www.connectingwithpeople.org/sites/default/files/Compassionate%20care%20ACK%20and%20PG.pdf

vi. An influential study by Isabel Menzies Lyth in the 1960s showed that caring for the sick can take its toll on those who care for them. She suggested that nurses can erect 'defences against anxiety' so that they can protect themselves from feelings of guilt, doubt and uncertainty. Essentially, health and care professionals can shut down their feelings of compassion in order to protect themselves. Isabel E. P. Menzies, Case-Study in the Functioning of Social Systems as a Defence against Anxiety: A Report on a Study of the Nursing Service of a General Hospital, *Human Relations* May 1960 13: 95-121

vii. http://www.healthwatch.co.uk/

viii. See recommendation 148.

ix. *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*, by Professor Don Berwick, August 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

x. Michael West, Richard Baker, Jeremy Dawson, Mary Dixon Woods, Richard Lilford, Graham Martin, Lorna McKee, Madeleine Murtagh, Patricia Wilkie, Quality and Safety in the NHS: Evaluating Progress, Problems and Promise, 2013, http://www.lums.lancs.ac.uk/files/quality-safety-nhs-e.pdf

xi. Michael West, Jeremy Dawson, Lul Admasachew and Anna Topakas, NHS Staff Management and Health Service Quality, 2011, https://www.gov.uk/government/publications/nhs-staff-management-and-health-service-quality; Michael West, Richard

Baker, Jeremy Dawson, Mary Dixon Woods, Richard Lilford, Graham Martin, Lorna McKee, Madeleine Murtagh, Patricia Wilkie, Quality and Safety in the NHS: Evaluating Progress, Problems and Promise, 2013, http://www.lums.lancs.ac.uk/files/quality-safety-nhs-e.pdf; Mary Dixon-Woods, Richard Baker, Kathryn Charles, Jeremy Dawson, Gabi Jerzembek, Graham Martin, Imelda McCarthy, Lorna McKee, Joel Minion, Piotr Ozieranski, Janet Willars, Patricia Wilkie, Michael West, Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study, 2013, http://qualitysafety.bmj.com/content/early/2013/08/28/bmjqs-2013-001947.full

xii. See Keogh Review, p22.

xiii. See the NHS England Call to Action at http://www.england.nhs.uk/2013/07/11/call-to-action/ and the Government spending round for 2013 at http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209036/spending-round-2013-complete.pdf

xiv. http://www.cqc.org.uk/public/hospital-intelligent-monitoring

xv. Examples include: Memorandum of Understanding between the Care Quality Commission (CQC) and the Nursing and Midwifery Council, available at http://www.cqc.org.uk/sites/default/files/media/documents/mou_Nursing and Midwifery Council_and_cqc.pdf; Memorandum of Understanding between the Care Quality Commission and Monitor, available at http://www.monitor-nhsft.gov.uk/about-monitor/what-we-do/working-together-patients; Partnership Agreement between Care Quality Commission and the NHS Trust Development Authority, available at http://www.ntda.nhs.uk/wp-content/uploads/2013/09/FINAL-20130822-Partnership-Agreement-CQC-TDA-EXTERNAL.pdf; Memorandum of Understanding between the Care Quality Commission and the General Medical Council http://www.General Medical Council-uk.org/about/partners/7500.asp; and a Joint Policy Statement to Accompany Care Bill Quality of Services Clauses, signed by Care Quality Commission, NHS England, Monitor and the NHS Trust Development Authority https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200446/regulation-oversight-NHS-trusts.pdf

xvi. For the respective roles of the Care Quality Commission, the NHS Trust Development Authority and Monitor, see *The regulation and oversight of NHS trusts and NHS foundation trusts* published by the Care Quality Commission, Monitor, NHS England and the NHS Trust Development Authority in May 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200446/regulation-oversight-NHS-trusts.pdf

xvii. See Keogh Review, p.26.

xviii. *The Healthy NHS Board 2013: Principles of good governance,* NHS Leadership Academy, http://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf

xix. For a copy of the standards, see http://www.professionalstandards.org.uk/docs/psa-library/november-2012---standards-for-board-members.pdf?sfvrsn=0.

xx. Michael West, Richard Baker, Jeremy Dawson, Mary Dixon Woods, Richard Lilford, Graham Martin, Lorna McKee, Madeleine Murtagh, Patricia Wilkie, Quality and Safety

in the NHS: Evaluating Progress, Problems and Promise, 2013, http://www.lums.lancs.ac.uk/files/quality-safety-nhs-e.pdf

xxi. Available at http://www.General Medical Council-uk.org/Quality_Improvement_Framework.pdf_39623044.pdf

xxii. Available at http://www.homeoffice.gov.uk/agencies-public-bodies/dbs/

xxiii. Available at An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings

xxiv. Available at Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report

xxv. Available at *A promise to learn – a commitment to act: Improving the Safety of Patients in England*

xxvi. Available at *Fundamental Review of Data Returns*

xxvii. Available at *What's it all for? Removing unnecessary bureaucracy in regulation*

xxviii. *Available at The Fundamental Review of Data Returns*

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