Department of Health

Patients First and Foremost

The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry

Cm 8576

Patients First and Foremost

The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry

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

March 2013

Cm 8576

£21.25

Any enquiries regarding this publication should be sent to us at FrancisResponse@dh.gsi.gov.uk

This publication is available for download at www.official-documents.gov.uk and from our website at www.gov.uk/dh

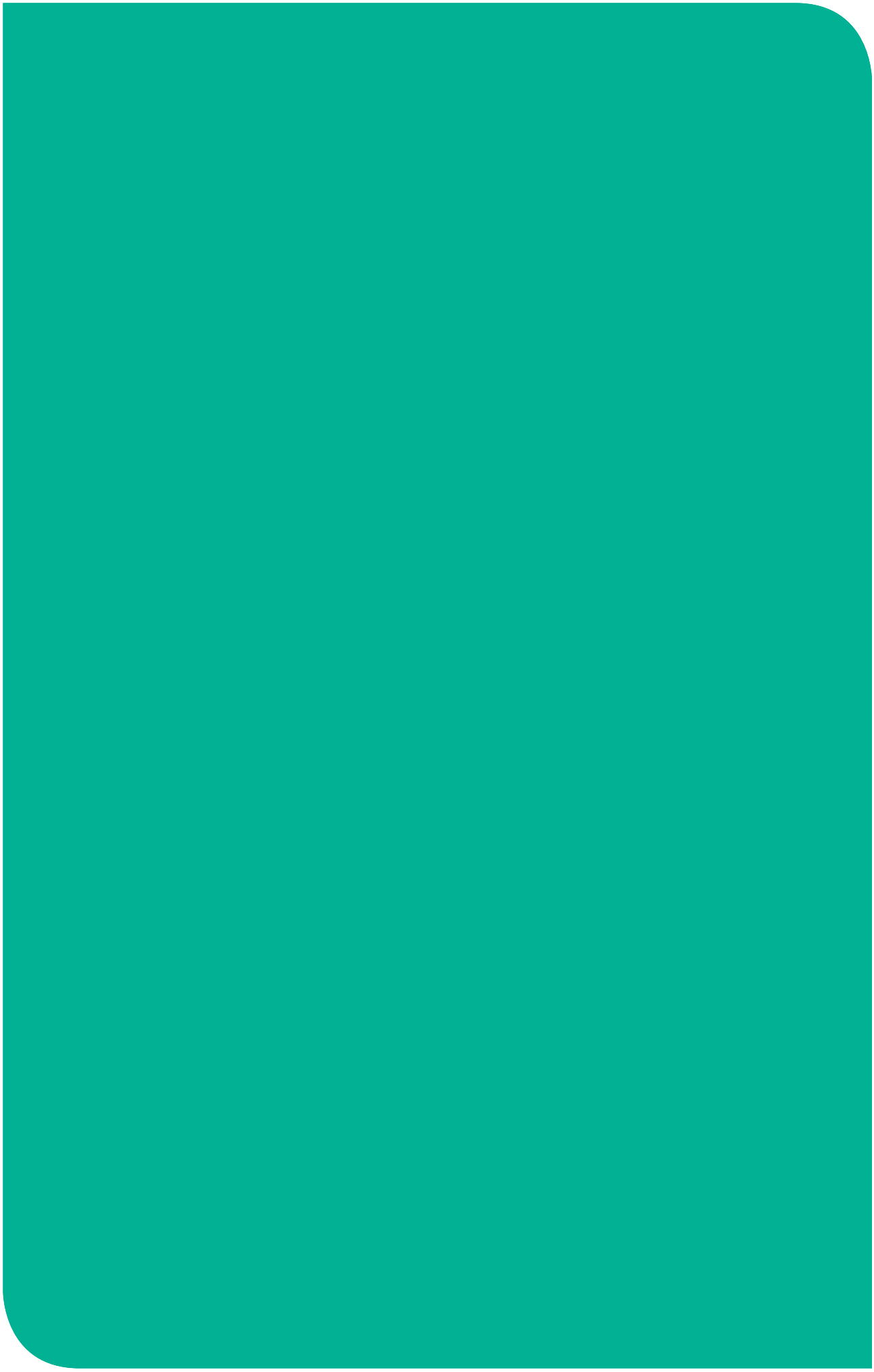
ISBN: 9780101857628

Printed in the UK by The Stationery Office Limited on behalf of the Controller of Her Majesty's Stationery Office

ID 2550149 03/13 28650 19585

Printed on paper containing 75% recycled fibre content minimum

Contents



Foreword by the Secretary of State for Health

"The NHS belongs to the people… It touches our lives at times of basic human need, when care and compassion are what matter most."

The NHS Constitution

"The system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm and from unacceptable, and in some cases inhumane, treatment that should never be tolerated in any hospital."

Robert Francis QC

"This Public Inquiry not only repeats earlier findings but also shows wider systemic failings so I would like to go further as Prime Minister and apologise to the families of all those who have suffered for the way that the system allowed such horrific abuse to go unchecked and unchallenged for so long. On behalf of the government – and indeed our country – I am truly sorry."

The Rt Hon David Cameron MP

The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry makes horrifying reading. At every level, individuals and organisations let down the patients and families that they were there to care for and protect. A toxic culture was allowed to develop unchecked which fostered the normalisation of cruelty and the victimisation of those brave enough to speak up. For far too long, warning signs were not seen, ignored or dismissed. Regulators, commissioners, the Strategic Health Authority, the professional bodies and the Department of Health did not identify problems early enough, or, when they were clear, take swift action to tackle poor care. They failed to act together in the interests of patients. This was a systemic failure of the most shocking kind, and a betrayal of the core values of the health service as set out in the NHS Constitution. We must never allow this to happen again.

We must make the quality of care as important as the quality of treatment. This means celebrating and spreading excellence in care; it means challenging mediocrity and those hospitals – and other providers of care – that are doing too little to learn and improve; and above all, it means protecting patients and people who use services from avoidable harm. We know that pockets of poor care exist in many parts of the NHS and this must never be acceptable.

This document is a call to action for every part of the system. Every individual, every team and every organisation needs to reflect with openness and humility about how they use the lessons from what happened at Mid Staffordshire NHS Foundation Trust to make a meaningful difference for people who use their services and their staff, and on how they are transparent and honest in demonstrating the progress they make to the public.

The Public Inquiry focused on how the wider system responded to failings in one hospital between 2005 and 2009, but the whole health and care system needs to listen, reflect and act to tackle the key challenges of culture and behaviour that the report makes so clearly. This initial response focuses on hospitals, but all of us across the health and care system must challenge ourselves to embrace the lessons of such a failure – including in primary and community care and in social care.

There are four key groups that are essential to creating a culture of safety, compassion and learning that is based on cooperation and openness.

First, and most importantly, patients and service users, and their families, friends and advocates – these are the people who know immediately if something is not right and who must feel welcome and safe in every part of our NHS and care and support system.

Second, the frontline staff who can foster change through their individual responsibilities, behaviours and values, and by working effectively together in strong teams – we know that those organisations that treat their staff well provide better care for patients.

Third, the leadership teams and, in particular, the boards of each organisation – they have the principal responsibility for ensuring that care in their organisations is safe and that those who use their services are treated as individuals, with dignity and compassion.

Fourth, the external structures surrounding each individual organisation, including commissioners, regulators, professional bodies, local scrutiny bodies and Government – they are there to ensure that all hospitals deliver good care, to raise concerns and to ensure action is taken. The system must get its structures, accountabilities and ways of working right to support this and to tackle any areas of poor performance rapidly and decisively.

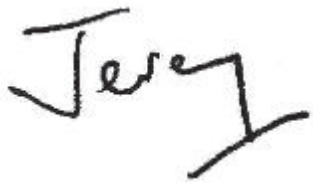
Action is needed at each level to enable the excellent care that already exists in the health and care system to become the norm, and to become what every person can expect of the NHS. We will start immediately by the Care Quality Commission appointing a new Chief Inspector of Hospitals to champion the interests of patients and make judgements about the quality of care. We will make hospital performance more transparent and easier to understand through a clear system of ratings. We will have a single failure regime that drives a coordinated and time limited response to unacceptable care. We will do this in a way that rationalises rather than adds to the bureaucratic burdens on frontline staff and on hospitals, and we will look to reward those organisations and individuals who deliver the highest quality care. We will also take steps to apply that approach beyond the hospital setting to other parts of the health and care system. The Care Quality Commission will appoint a Chief Inspector for Social Care.

We will take further action to improve safety and learn the right lessons when things go wrong. We will create a system that is much more responsive to feedback from staff, patients, service users and their families, and as part of this we will ensure that everyone is able to say whether they would recommend the service they received to their family and friends. We will foster a climate of openness, where staff are supported to do the right thing and where we put people first at all times.

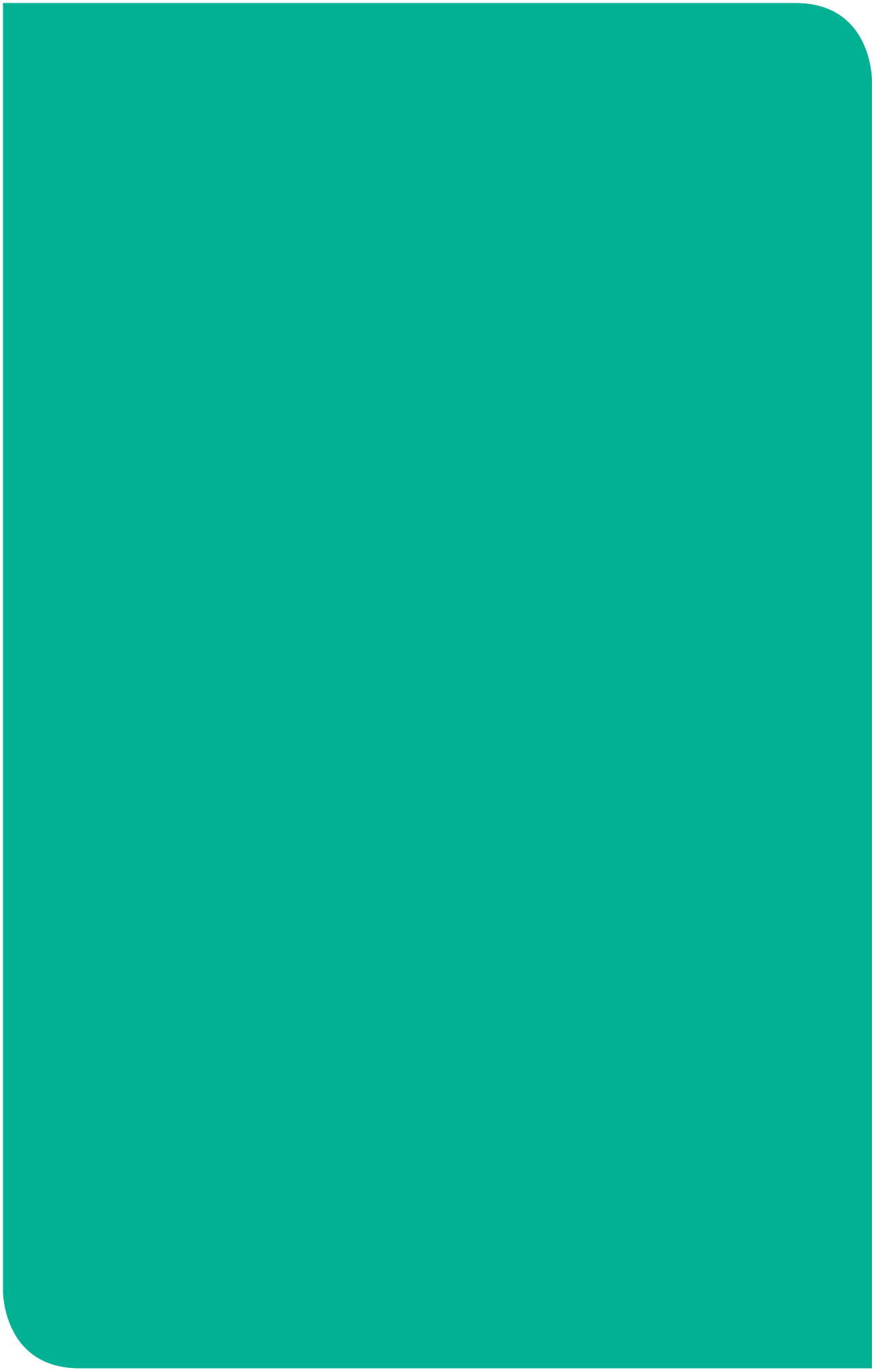
I have written to the Chairs of all NHS Trusts asking them to hold events where they listen to the views of their staff about how we safeguard the core values of compassion as the NHS gets ever busier. I will listen to these solutions and hear directly people's concerns and ideas.

My Ministerial team and Department will do the same, as will the Chief Executives and Chairs of the organisations who together provide the leadership and assurance of the health and care system.

I am grateful to Robert Francis and his team for this seminal report, which marks a crucial moment for the whole health and care system. We all need to learn from the Inquiry findings, then act with determination and tenacity to transform the health and care system to deliver the consistently safe and compassionate care we all want for ourselves, our friends and our families. Robert Francis concluded his letter to me by saying that he hoped the recommendations in his report could '*put patients where they are entitled to be* – ***the first and foremost consideration of the system and everyone who works in it.***' We are determined to act together to make this a reality.



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 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**

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

much to us all. What happened in Mid Staffordshire NHS Foundation Trust 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 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 settings.**

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.

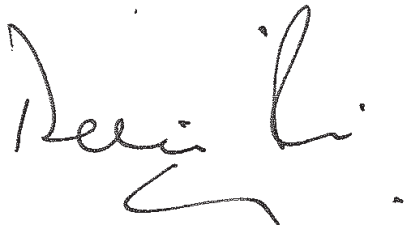
9. Healthcare is complex and we are part of a complicated system. Building on a foundation of fundamental and inviolable standards, **we will build a single set of nationally agreed and locally owned measures of success, focussed on what matters most to patients.** They must be credible and independently 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. **Blind adherence to 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 speaking up, 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 of us will set out 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 NHS Foundation Trust, 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.



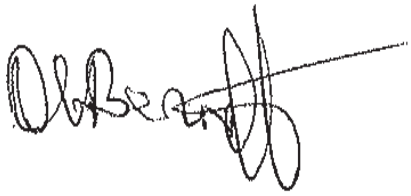
David Prior, Chair,
Care Quality Commission

Una O'Brien, Permanent Secretary,
Department of Health

Professor Sir Peter Rubin, Chair,
General Medical Council

Sir Keith Pearson, Chair,
Health Education England

Sir Merrill Cockell, Chair,
Local Government Association

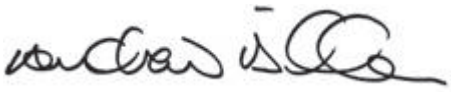


Dr David Bennett, Chair,
Monitor

Professor Malcolm Grant, Chair,
NHS Commissioning Board

Michael O'Higgins, Chair,
NHS Confederation & NHS Employers

Jan Sobieraj, Managing Director,
NHS Leadership Academy



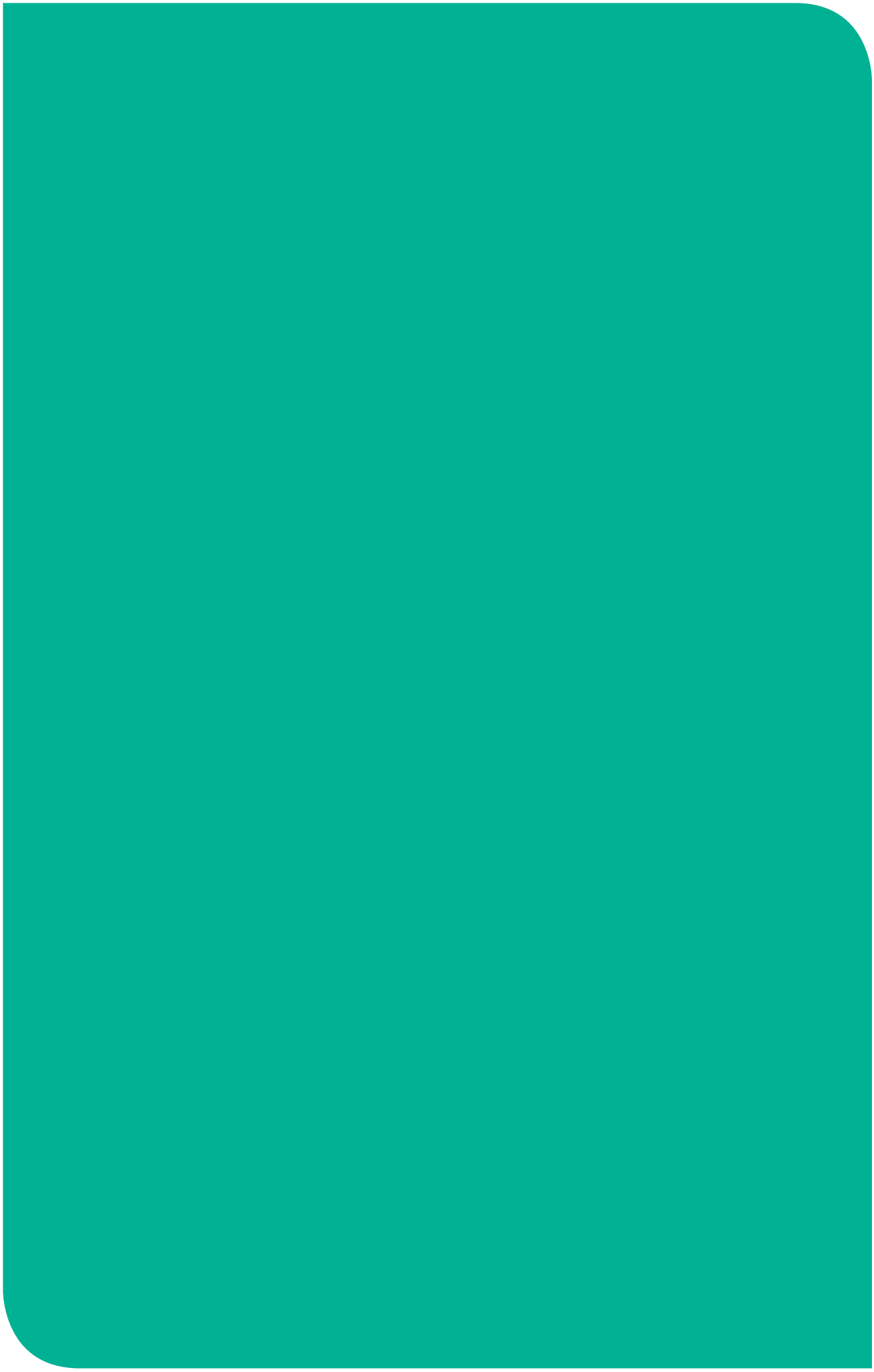
Sir Andrew Dillon, Chief Executive,
National Institute for Health
and Clinical Excellence

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, Chairman,
Public Health England



Executive Summary

Introduction

1. This document sets out an initial overarching response, on behalf of the health and care system as a whole, to the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Inquiry). It details key actions to ensure that patients are '*the first and foremost consideration of the system and everyone who works in it'* and to restore the NHS to its core humanitarian values. It sets out a collective commitment and a plan of action to eradicate harm and aspire to excellence.

2. This is a watershed moment for the NHS and a call to action for every clinician, everyone working in health and care, and every organisation. Many thousands of committed, caring and hard working staff deliver good or excellent NHS care every day of the year. Yet in one hospital from 2005 to 2009 many patients received appalling care, and the wider system failed to identify the problem and then failed to share information and act on warning signs. This was unforgivable and must never happen again. Yet whilst the case at Mid Staffordshire NHS Foundation Trust was unique in its severity and duration, pockets of poor care do exist elsewhere and some of the features that contributed to the tragedy – patients and families ignored, staff disengaged or unable to speak up – point to wider problems.

3. Robert Francis' first independent inquiry looked at what went wrong inside the Trust and reported in 2010. Since then, we have taken action to strengthen the focus on the quality of care and the safeguards to protect patients from harm, including through the work of the National Quality Board, the Nursing and Care Quality Forum, the improved processes for Foundation Trust authorisation, and the introduction of dignity and nutrition inspections amongst many other measures.

4. But it is clear we now need to go further. This response starts from a simple premise and a simple goal – that the NHS is there to serve patients and must therefore put the needs, the voice and the choices of patients ahead of all other considerations. This response to the shocking findings of the Inquiry sets out a five point plan to revolutionise the care that people receive from our NHS, putting an end to failure and issuing a call for excellence:

A. **Preventing problems**

B. **Detecting problems quickly**

C. **Taking action promptly**

D. **Ensuring robust accountability**

E. **Ensuring staff are trained and motivated**

5. Delivering this response will end decades of complacency about poor care, by detecting and exposing unacceptable care quickly and ensuring that the system takes real responsibility for fixing problems urgently and effectively. It will drive coasting hospitals to improve and it will give greater freedom to care for the good and the excellent. It will

underpin the compassionate values of NHS staff with the right training and leadership needed to ensure consistently safe, effective and respectful care. It puts in place fair and robust systems to ensure that where organisations let patients, staff and the NHS down, there is proper accountability for those failings.

6. The recommendations of the Inquiry focussed on acute hospitals like Mid Staffordshire NHS Foundation Trust and so too does this response to the Inquiry. However, we know that many of the messages from the Inquiry are equally relevant to other health and care settings. Issues such as the culture of care and the vital importance of listening to and being open with patients, their families and advocates apply across the health and care system. These sorts of problems were identified not just in Mid Staffordshire NHS Foundation Trust but also in the terrible failures of care at the independent sector assessment and treatment unit, Winterbourne View.[1]

A. Preventing Problems

7. Together the changes set out in this document will help to secure a consistent culture of compassionate care with patients' interests at its very heart. At local level, commissioners will work with hospitals to identify and tackle poor care. A Chief Inspector of Hospitals will shine a powerful light on the culture of hospitals, driving change through fundamental standards and national ratings which put the experience of patients at the centre of what the NHS does and the way in which its success is judged.

8. The measures in this document – radical transparency, excellence in leadership, clarity of accountability, consequences for failure and rewards for the very best – will together put in place the action needed to revitalise the culture of the NHS around a consistent focus on the needs of the patients it serves.

Time to Care

9. But to do so, leaders need time to lead and staff need time to care. In a busier NHS, we will ensure that paperwork, box ticking and duplicatory regulation and information burdens are reduced by at least one third. With a single version of the truth in the Chief Inspector's balanced assessment, there will be a single national hub – the Health and Social Care Information Centre – for collecting information, and it will have a duty to seek to reduce the information burden on the service year on year.

Safety in the DNA of the NHS – The Berwick Review

10. Professor Don Berwick, former adviser to President Obama, will be working with the NHS Commissioning Board to ensure a robust safety culture and a zero tolerance of avoidable harm is embedded in the DNA of the NHS.

B. Detecting Problems Quickly

Chief Inspector of Hospitals Making Assessments Based on Judgement as Well as Data

11. The Care Quality Commission will appoint a powerful Chief Inspector of Hospitals later this year. Armed with a sophisticated battery of information about hospitals from across the system, but, crucially, informed by expert judgements of inspectors who have walked the wards, spoken to patients and staff, and looked the board in the eye, the Chief Inspector will make an assessment of every NHS hospital's performance, drawing on the views of commissioners, local patients and the public. The Care Quality Commission will be supported by local Quality Surveillance

Groups, encompassing all the key players in the system, so that there are effective arrangements in place to identify rapidly those hospitals where there is a risk or reality of poor patient care.

Expert Inspectors, not Generalists

12. We will bring an end to the days of generalist inspectors briefly visiting organisations who often have little specialist insight into the organisations they visit. From this year, new and thorough expert-led inspections will get to the heart of how hospitals are serving their patients, exposing the poor, spurring on the complacent and celebrating the achievements of the good and the excellent. Just as OFSTED acts as a credible, respected and independent arbiter of the best and the worst in our schools, the Chief Inspector will shine a light on how our hospitals are serving our patients. The Chief Inspector will become the nation's whistleblower – naming poor care without fear or favour from politicians, institutional vested interests or through loyalty to the system rather than the patients that it serves.

13. A 'comply or explain' approach to known good practices will be used in inspections. So, where there are well-established practices that benefit patients (for example nursing rounds, supervisory ward sisters, evidence-based staffing levels, and independent collection of patient experience data), inspectors will expect to see these being used across hospitals, or a valid explanation given if this is not the case.

Ratings – A Single Balanced Version of the Truth

14. We intend to give the Care Quality Commission the power to conduct ratings at the earliest opportunity and will work with the Nuffield Trust to develop these proposals further. Until now there has been a confusing welter of information about hospitals and the public cannot easily tell how well their local hospital is doing. In the future the Chief Inspector will ensure that there is a single version of the truth about how their hospitals are performing, not just on finance and targets, but on a single assessment that fully reflects what matters to patients. As in education, the Chief Inspector will make a balanced assessment of hospitals and give them a single, clear rating, which could be "outstanding", "good", "requiring improvement" or "poor". Outstanding hospitals will be given greater freedom from regulatory bureaucracy. The Friends and Family Test for both patients and staff will be a vital component of the rating. Everyone in the system, whether regulator or commissioner, will use the same single set of data to judge success.

Chief Inspector of Social Care

15. There will be a new Chief Inspector of Social Care who will adopt a similar approach to social care and will be charged with rating care homes and other local care services, promoting excellence and identifying problems.

Publication of Individual Speciality Outcomes

16. A new spirit of candour and transparency will be essential for exposing poor care. In line with the Nuffield Trust recommendations, information about hospitals will not be limited to aggregated ratings but it will be possible to drill down to information at a department, specialty, care group and condition-specific level. As a starting point, the NHS Commissioning Board will extend the transparency on surgical outcomes from heart surgery, which has been hugely successful, to cardiology, vascular surgery, upper gastro intestinal surgery, colorectal surgery, orthopaedic surgery, bariatric surgery, urological surgery,

head and neck surgery and thyroid and endocrine surgery.

Penalties for Disinformation, and a Statutory Duty of Candour

17. Mortality data must be interpreted with care, but it must also be accurate so that the public and patients can trust that they are hearing an honest and fair account. So there will be tough penalties and we will consider the introduction of additional legal sanctions at corporate level for organisations that are found to be massaging figures or concealing the truth about their performance. A statutory duty of candour on providers to inform people if they believe treatment of care has caused death or serious injury, and to provide an explanation, will reinforce the existing contractual duty.

A Ban on Clauses Intended to Prevent Public Interest Disclosures

18. Contractual clauses that seek to prevent NHS staff from speaking out on issues like patient safety, death rates and poor care will come to a halt. Staff who disclose such problems should be supported, not vilified.

Complaints Review

19. A review of best practice on complaints will 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.

C. Taking Action Promptly

Fundamental Standards

20. The Care Quality Commission, working with NICE, commissioners, professionals, patients and the public, will draw up a new set of simpler fundamental standards which make explicit the basic standards beneath which care should never fall. This will be in language that both the public and professionals can easily understand.

Time Limited Failure Regime for Quality as Well as Finance

21. In the past, when poor care was detected, it was too often put in a “too difficult” pile. Patients have been left with no one acting with urgency on their behalf to ensure a decent standard of care. This inaction must and will stop.

22. The Chief Inspector will identify poor care in public, a call to action to the hospital itself, its commissioners and the organisations responsible for their oversight. Where normal commissioner engagement with local hospitals has been unable to address significant concerns about patient care, a new time-limited three stage failure regime, encompassing not just finance, but for the first time quality, will ensure that where fundamental standards of care are being breached, firm action is taken until they are properly and promptly resolved.

23. In the first stage, the Chief Inspector will require the hospital board to work with its commissioners to improve, within a fixed time period, but the Care Quality Commission will not be responsible for making improvement happen. That will first be a task for the Board of the hospital, working with its commissioners. In the second stage, if the hospital with commissioners is unable to resolve its own problems, then the Care Quality Commission would call in Monitor or the NHS Trust Development Authority to take action. In the final stage, where fundamental problems in the hospital mean that its problems have not been resolved, the Chief Inspector will initiate a failure regime, in which the Board could be suspended or the hospital put into administration, whilst ensuring continuity of care.

24. The Care Quality Commission, the NHS Commissioning Board, Monitor and the NHS Trust Development Authority will be required to agree together the data and methodology for assessing hospitals. This will ensure a single set of expectations on hospitals of what is required of them which are aligned with the way in which commissioners, led by clinicians and guided by the views of local patients, ensure high quality care in the hospitals for which they are responsible. Providers will demonstrate, through annual Quality Accounts, how well they are meeting that single set of expectations.

D. Ensuring Robust Accountability

Health and Safety Executive to use Criminal Sanctions

25. Where the Chief Inspector identifies criminally negligent practice in hospitals, the Care Quality Commission will refer the matter to the Health and Safety Executive to consider whether criminal prosecution of providers or individuals is necessary. The Department of Health will ensure sufficient resources are available to the Health and Safety Executive for this role.

Faster and More Proactive Professional Regulation

26. The General Medical Council, the Nursing and Midwifery Council and the other professional regulators are hampered by an outdated legislative framework that is too slow and reactive in tackling poor care by individual professionals. As part of the implementation of the Law Commission's review, we will seek to legislate at the earliest possible opportunity to overhaul radically 150 years of complex legislation into a single Act that will enable faster and more proactive action on individual professional failings.

Barring Failed NHS Managers

27. To deal with the small numbers of managers who let their patients and the NHS down through gross misconduct, and prevent them from moving to new jobs in the NHS, we will introduce a national barring list for unfit managers, based on the barring scheme for teachers.

Clear Responsibilities for Tackling Failure

28. At a national level, these proposals, taken together, will resolve the confusion of roles and responsibilities in the system, so it is clear where the buck stops on poor care beyond the action that providers and commissioners take themselves. The Chief Inspector will identify failing standards in NHS Trusts and Foundation Trusts. Where necessary, Monitor and the NHS Trust Development Authority will resolve them with hospitals and their commissioners. The Department of Health will ensure that everyone plays their part on patients' behalf.

E. Ensuring Staff are Trained and Motivated

HCA Training before Nursing and other Degrees

29. Starting with pilots, every student who seeks NHS funding for nursing degrees should first serve up to a year as a healthcare assistant, to promote frontline caring experience and values, as well as academic strength. They will also provide students with helpful experience for managing healthcare assistants when they qualify and enter practice. The scheme will need to be tested and implemented carefully to ensure that it is neutral in terms of costs. Health Education England will work with the Nursing and Midwifery Council, professional leaders and trade unions in developing the pilots. We will

explore whether there is merit in extending this principle to other NHS trainees.

Revalidation for Nurses

30. Building on the historic introduction of medical revalidation, which offers proactive assurance of individual doctors, when the Nursing and Midwifery Council turns around its current poor performance we will work with them to introduce a proportionate and affordable national scheme to ensure all practising nurses are up to date and fit to practise.

Code of Conduct and Minimum Training for Health and Care Assistants

31. Camilla Cavendish is reviewing how best to ensure healthcare assistants can provide safe and compassionate care to patients. We are today publishing standards of conduct and training for all care assistants. The Chief Inspectors will ensure that employers meet their registration requirements that all health and care support workers are properly trained and inducted before they care for people.

Barring System for Healthcare Assistants

32. The Chief Inspector of Hospitals will assure, as part of inspections, that all hospitals are meeting their legal obligations to ensure that unsuitable healthcare assistants are barred from future patient care by properly and consistently applying the Home Office's barring regime.

Attracting Professional and External Leaders to Senior Management Roles

33. The NHS Leadership Academy, in addition to its existing work to ensure that top leaders have the right skills and the right values, will initiate a major programme to encourage new talent from clinical professionals and from outside the NHS into top leadership positions. From within existing resources, working with world class universities, we will develop an elite fast track programme for talented leaders outside the NHS to attract the brightest and best to top NHS jobs. In addition we will invest in MBA style programmes to ensure that clinicians with a talent for leadership are supported in becoming the clinical Chief Executives of tomorrow.

Frontline Experience for Department of Health Staff

34. At the centre of the system, the Department of Health will need to reconnect with the patients it serves. Within four years, every civil servant in the Department will have sustained and meaningful experience of the frontline with Senior Civil Service and Ministers leading the way.

Next Steps

35. Key organisations across health and care will take the action needed to make this document a reality for patients and the Government will, as Robert Francis recommends, draw together a report on progress each year.

36. In addition, all NHS hospitals should set out how they intend to respond to the Inquiry's conclusions before the end of 2013.

Introduction

"Until the scandalous decline in standards is reversed, it is likely that unacceptable levels of care will persist and therefore it is an area requiring the highest priority. There is no excuse for not tackling it successfully. Much of what needs to be done does not require additional financial resources, but changes in attitudes, culture, values and behaviour."

Robert Francis QC

1. This document sets out an initial response to Robert Francis' challenge to make patients '*the first and foremost consideration of the system and everyone who works in it*'. It has been developed on behalf of the health and care system and in partnership with the signatories of the common statement of purpose above.

2. The Inquiry's examination of the system's role in the appalling failures of care between 2005 and 2009 in Mid Staffordshire NHS Foundation Trust offers a stark, sobering and unpalatable analysis of a system failing to put patients first, a system that lost its way.

3. At heart, Robert Francis' report[2] is a powerful call to action on tackling invidious aspects of NHS culture that have arguably become more pronounced as the health service has become busier and the needs of patients more complex.

4. Our NHS is rightly celebrated, performing incredible feats at the cutting edge of medicine and surgery. Its staff, in the vast majority of cases, are dedicated, skilled, kind and committed people. Yet in parts it is failing, sometimes atrociously, in the very basics of care: failing to ensure patients have food they can eat and water to drink; failing to provide the correct dose of medicine or pain relief at the right time; too often failing vulnerable people; failing to listen to what patients and families say or to offer a kind word or hand when one is most needed.

5. The essential diagnosis from the Inquiry is of an NHS that had veered, or was pushed, too far from its core humanitarian values and in too many places had its priorities wrong. Targets and performance management in places overwhelmed quality and compassion. Top down management instructions drowned out patient voices. Pressure to perform and fear of failure led to a controlling and defensive approach from organisations. Regulators, commissioners and others in the system became focused on their own roles and, in some cases, lost sight of the patients they were there to serve.

6. The job now is to put the system back on track and to put in place sustainable measures to ensure that it continues to drive improvements. This means restating clearly our common purpose and binding principles – that quality is as important as finance, that patient interest comes before institutional interest, that we all work together in the interests of patients and are open and

transparent in our actions. Though Robert Francis' report focuses particularly on nursing and medicine, it is a call to action for the whole clinical workforce and everyone who works in health and care.

7. Although the Inquiry and this response focus primarily on NHS hospitals the core messages are applicable to all staff working throughout the health and care system, whatever the setting. The failures of care identified at Winterbourne View Hospital – a hospital far away from Mid Staffordshire NHS Foundation Trust both geographically and in the nature of its services – demonstrated that the interests of patients need to be foremost, whatever their individual needs and wherever they are cared for. This call for action is as applicable to staff working in an independent hospital or treatment unit for patients with mental health problems or learning disability as it is for staff in an acute hospital.

8. Robert Francis' report makes clear that changing organisational culture is pivotal to achieving meaningful change. Transforming the health and care system cannot be done from Whitehall and it cannot be done overnight. This response states a collective commitment to facilitate this transformation and early actions, but it is for every part of the health and care system to think, talk and act with drive and ambition to tackle avoidable harm and enable compassionate care. In supporting this transformation, each hospital in the country has been asked to hold listening events with its staff to reflect on Robert Francis' report and consider how to safeguard the core values of compassion and care in a busy NHS.

9. Alongside his overarching critique of culture, Robert Francis has drawn out five key themes under which the majority of his recommendations sit: **values and standards**; **openness, transparency and candour**; **leadership**; **compassion and care**; and **information**.

Action Since the First Inquiry

10. The Department of Health and national agencies have acted on many of these areas both during the Inquiry and since it finished hearing evidence in December 2011. For example:

(a) **Values and standards** – the NHS Constitution has been revised to give more prominence to values and the Care Quality Commission has increased its number of compliance inspectors, and improved their training. All inspections are now unannounced to strengthen the assessment process for essential standards. In addition, Patient Led Assessment of the Care Environment (PLACE) assessments will start in April 2013 with local people going into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance.

(b) **Openness, transparency and candour** – actions include strengthening the protection and support available to whistleblowers, including a right to raise concerns within staff contracts; the amendment of the NHS Constitution to include explicit rights and pledges on whistleblowing; new guidance to employers; the extension of the national helpline to include staff in social care; the strengthening of the annual NHS Staff Survey, and making crystal clear that compromise agreements should not stop staff speaking out on matters of public interest. In addition, the NHS Standard Contract for 2013/14 will include a contractual duty of candour on all providers to be open and honest with patients when things go wrong with penalties for breaching this duty.

(c) **Leadership** – the NHS Leadership Academy was established in 2012 and

is already supporting system leaders through a range of programmes. In addition, the Professional Standards Authority for Health and Social Care has published standards for members of NHS boards and Clinical Commissioning Group's governing bodies that put respect, compassion and care for patients at the heart of leadership and good governance in the NHS.

(d) **Compassion and care** – *Compassion in Practice*[3] (the nursing, midwifery and care staff vision and strategy for England) was launched in December 2012. It is based on the values and behaviours of the "6Cs" – Care, Compassion, Competence, Communication, Courage and Commitment. Over the last three months nurses, midwives and care staff, as well as stakeholders at national and organisational level, have developed implementation plans to support the delivery of the values and behaviours of the "6Cs". In addition, the Government has announced a £13 million innovation fund for the training and education of unregulated health professionals and Skills for Health and Skills for Care have been developing minimum training standards and a code of conduct for healthcare support workers and adult social care workers in England.

(e) **Information** – from April 2013, a network of local and regional Quality Surveillance Groups (QSGs) will bring together commissioners, regulators, local Healthwatch representatives and other bodies on a regular basis to share information and intelligence about quality across the system and proactively spot potential problems. Also from April 2013, Quality Accounts will include comparable data from a set of quality indicators linked to the NHS Outcomes Framework including the summary hospital-level mortality indicator, infection rates and reported levels of patient safety incidents. More generally, the *Power of Information*[4] sets out the Department's ten-year framework for transforming information for health and care.

11. In addition, we have published our response to the events at Winterbourne View in Transforming Care: a national response to Winterbourne View Hospital and a programme of transformation is underway including reviewing care placements and supporting everyone inappropriately in hospital to move to community-based support. A Joint Improvement Programme led by the Local Government Association and NHS Commissioning Board has been set up to support this transformation in care.

12. There is much more to do under each of Robert Francis' themes and most of the recommendations in Robert Francis' report we accept, either in principle or in their entirety. This report, six weeks on, is not, and could not be, a full response to each and every one of Robert Francis' 290 recommendations. As he notes '*some recommendations are of necessity high level and will require considerable further detailed work to enable them to be implemented*.' To rush ahead would mean that they would not be given the full and collective consideration they deserve and would limit the clinical engagement and patient and public involvement that will be so important. The report, therefore, provides an overarching response, setting out key early priorities.

13. We recognised also that there are vital questions implied by the report findings about how we ensure older people get excellent treatment care and support when they need it to help people stay in good health throughout their lives, maintain control and independence, and avoid or postpone needing hospital treatment or long-term

residential care. This response focuses particularly on urgent priorities to ensure safe, compassionate care in hospitals, and we will take forward further work later this year on improving prevention, integration and primary care to help keep more people out of hospitals.

14. Over the coming months, many of the organisations who have contributed to this response will produce their own action plans and we expect that everyone will respond to the Inquiry's first recommendation to set out how they will act on the Inquiry's recommendations. All NHS hospitals should also set out how they intend to respond to the Inquiry's conclusions before the end of 2013. This autumn, we will publish a document drawing this together into a system-wide update on progress and next steps. We will continue to ensure Robert Francis' report drives real change, reporting annually on our progress and where we need to take further action.

Chapter One – Preventing Problems

Summary

The measures in this document – radical transparency, excellence in leadership, clarity of accountability, consequences for failure and rewards for the very best – will together put in place the measures needed to revitalise the culture of the NHS around a consistent focus on the needs of the patients it serves. In particular, the creation of a new Chief Inspector of Hospitals will shine a powerful light on the culture of hospitals, driving change through national ratings which put the experience of patients at their heart.

But to do this well leaders need time to lead and staff need time to care, unconstrained by a culture of compliance. In a busier NHS, we will ensure that paperwork, box ticking and duplicatory regulation and information burdens are reduced by at least one third. With a single version of the truth in the Chief Inspector's balanced scorecard and assessment, there will be a single national portal – the Health and Social Care Information Centre – for collecting information, and it will have a key role in reducing the information burden on the service year on year.

Professor Don Berwick, former adviser to President Obama, will be working with the Commissioning Board to ensure safety and a zero tolerance of avoidable harm is embedded in the DNA of the NHS.

The Government will consult on amendments to the NHS Constitution to ensure that it fully reflects the findings of the Public Inquiry.

Achieving Culture Change

1.1 Much of this response is focussed on new and radical approaches to identifying problems quickly, ensuring swift action to address them, holding organisations to account and ensuring that staff have the skills, motivation and support they need to give the best to patients. But our first focus must be to prevent poor care occurring in the first place. And the issue of culture is absolutely central to this task. To prevent a reoccurrence of the events at Mid Staffordshire NHS Foundation Trust and to ensure that all care is consistently to the standard that patients, the public and staff themselves wish to see, we need to ensure a culture that is consistently supportive of this aim.

1.2 Robert Francis' report sets a profound challenge to change the culture of the health and care system so that it never loses sight of its core values of compassion and care. This demands "*the engagement of every single person serving patients*", from the hospital porter to the Secretary of State for Health.

1.3 The analysis of what went wrong shows Mid Staffordshire NHS Foundation Trust's leadership and board focused on the wrong things – "hitting the target and missing the point" – and a wider system where warning signs were dismissed or unheeded and crucial information was not shared. Robert Francis' first independent review told horrifying stories about what this meant for patients and their families:

> *"In the next room you could hear the buzzers sounding. After about 20 minutes you could hear the men shouting for the nurse, "Nurse, nurse", and it just went on and on. And then very often it would be two people calling at the same time and then you would hear them crying, like shouting "Nurse" louder, and then you would hear them just crying, just sobbing, they would just sob and you just presumed that they had had to wet the bed. And then after they would sob, they seemed to then shout again for the nurse, and then it would go quiet..."*
>
> The daughter of a patient in ward 11
>
> *"We got there about 10 o'clock and I could not believe my eyes. The door was wide open. There were people walking past. Mum was in bed with the cot sides up and she hadn't got a stitch of clothing on. I mean, she would have been horrified. She was completely naked … covered in faeces ... It was everywhere. It was in her hair, her eyes, her nails, her hands and on all the cot side, so she had obviously been trying to lift herself up or move about, because the bed was covered and it was literally everywhere and it was dried. It would have been there a long time, it wasn't new."*
>
> The daughter-in-law of a 96-year-old patient

1.4 The cultural challenge faced by the NHS has been talked about in many ways. The key is that boards and leaders need to create environments where staff feel supported to cope with the day to day risks and challenges of health and care work. This also enables openness: mistakes will sometimes happen – staff need to know it is safe to admit them. It also enables compassion: under stress, anyone can find it hard to be caring – staff need to know it is safe to ask for the support they need to really be there for patients.

Common Values – the NHS Constitution

1.5 Every team, within every individual organisation, will have its own distinct culture, but the Government agrees with Robert Francis' conclusion that the common values and cultural attributes that we seek to foster across the NHS should be set out in the NHS Constitution[5]. We are publishing a revised Constitution that takes account of the lessons from the Inquiry, with an increased emphasis on common values, and in particular the fundamental value of "working together for patients". We will consult on further amendments to the Constitution later this year to respond in full to Robert Francis' recommendations.

1.6 However, we know that publishing a national document is not going to change cultures in wards and teams across the country. What matters is whether teams are inspired to own and live the values set out in the Constitution. The rest of this chapter considers what is needed to enable this. The rest of this document sets out a series of measures which help to ensure that the leaders of organisations providing care make the NHS Constitution and its values a meaningful reality for patients and staff every day.

The Board – Critical for a Compassionate Culture

1.7 Boards have a critical role in ensuring that their organisations are well governed and deliver the organisation's strategic objectives. They are responsible for shaping those objectives, providing clear accountability for their delivery and shaping a culture that positively promotes safety, effectiveness, compassion, ambition, openness and innovation.

1.8 In his report, Robert Francis recognises the urgent need for cultural change in the NHS. Effective boards will be essential if this requirement is to be fully realised; they will be at the helm of each NHS service provider, constantly checking that every department, every team and every individual is focused on and wants to deliver the best possible patient care.

1.9 The 2010 publication *The Healthy NHS Board*[5] articulated the role of boards in the NHS and made it clear that patient safety and the quality of services is the key, over-arching priority. This document is currently being reviewed by the NHS Leadership Academy, working with key partners including the Care Quality Commission, Monitor and the NHS Trust Development Authority to reflect the lessons learned from Robert Francis' report. It will then provide a statement of what a good NHS board looks like that everyone, including the boards themselves and their regulators, can understand and work towards.

1.10 The NHS Trust Development Authority, with its responsibility for exercising the Secretary of State's powers to appoint the chair and non-executive directors of NHS trusts, has for the first time the opportunity to ensure that there is a direct correlation between these important appointments and the broader oversight of the provider. The NHS Trust Development Authority will be able to ensure that only people with the skills and experience needed to help meet the developing needs of these organisations are appointed as their chairs and non-executive directors, and will work directly with boards to ensure they have the support they need to be wholly effective in their roles. Monitor will be carrying out work in parallel to ensure that the governors and non-executives of NHS foundation trusts have the support they need to hold their organisations to account effectively and to build and sustain the right organisation cultures.

1.11 Recognising the importance of the role of boards in the success of NHS organisations, assessment of the performance and future capability of the board will be an increasingly important element of an NHS foundation trust application for both the NHS Trust Development Authority and Monitor.

1.12 Importantly, the new Chief Inspector of Hospitals, will consider carefully the culture of organisations and the quality of their boards in making judgements about their overall ratings.

Clinically-Led Commissioning, Focused on Outcomes

1.13 Robert Francis' report provided a stark account of an organisation that focused on targets and processes at the expense of its core responsibilities to patients. All parts of the NHS must focus on outcomes rather than processes, and on what matters most: providing safe, effective care and a positive patient experience.

1.14 There is a place for targets in the NHS, but they became too numerous, too tight and their implementation too obsessive, based on national political priorities rather than the views of local people and local clinicians. Since 2010, we have started to

change the approach. We have moved from a system focused on targets and processes to one focused on outcomes, and on what matters most to patients: safe, effective care and a positive patient experience. Local commissioners, led by clinicians and driven by the views of local patients, will be setting the priorities. The NHS Outcomes Framework sets out the outcomes and corresponding indicators that will be used to hold the NHS Commissioning Board to account for the outcomes it secures through its oversight of the commissioning of health services from 2012/13. These new arrangements will ensure an NHS that looks to patients, not politicians.

1.15 The reforms to the NHS, to be introduced in April 2013, will significantly strengthen the commissioning system to deliver better quality, patient-centred healthcare. The focus of this new commissioning system, made up of clinically-led clinical commissioning groups, supported by the NHS Commissioning Board, is explicitly on improving outcomes, as defined by the NHS outcomes framework, giving commissioning a new clarity of purpose.

1.16 The Secretary of State's Mandate to the NHS Commissioning Board sets out clearly the improvements in outcomes which should be achieved. These include reducing the number of incidents of avoidable harm and making measurable progress to embed a culture of patient safety in the NHS, including through improved reporting of incidents. These aims are consistent with Robert Francis' recommendations.

1.17 Placing local clinicians in the lead for commissioning represents a fundamental change to drive better alignment with the safety and effectiveness of patient care. In the new commissioning system:

- Patients will have access to the information they want to make choices about their care and Healthwatch will strengthen their collective voice nationally and locally.
- A culture of open information, active responsibility and challenge will help ensure that patient safety is put above all else.
- A contractual duty of candour (now to be strengthened by a statutory duty) will require hospitals to be open with patients when things go wrong.
- The NHS Outcomes Framework will be used to hold the NHS Commissioning Board to account for the improvements it makes through the commissioning of health services.

1.18 The NHS Commissioning Board will provide effective new leadership for the commissioning system. All NHS organisations need to work to connect more effectively with patients and the public. To help support this change, the NHS Commissioning Board will adopt the name 'NHS England', a title which will provide a clearer and less technical sense of its remit. This change will not alter in any way the NHS Commissioning Board's role, power, or functions.

1.19 As part of the process of authorising Clinical Commissioning Groups (CCGs), the Board must be satisfied that they are able to commission safely and to exercise their functions in relation to improving quality, reducing inequality and delivering improved outcomes within the available resources. The NHS Commissioning Board will also hold CCGs to account for the quality outcomes they achieve and for financial performance, and will have the power to intervene where there is evidence that CCGs are failing, or are likely to fail, their functions. Through the new role of health and wellbeing boards, local commissioners of health, care, and other services will have a new opportunity to work in partnership together to improve outcomes for the whole population. As a member, and

the convenor, of Quality Surveillance Groups (QSG), the NHS Commissioning Board will work with CCGs, regulators, providers and other partners to gather intelligence and information from local patients and services, to raise any concerns about quality, and to agree what action should be taken to address them. In future, as the Chief Inspector of Hospitals is established, the Care Quality Commission will play the lead role in Quality Surveillance Groups in assessing quality problems and Monitor and the NHS Trust Development Authority will lead on overseeing action to address them.

1.20 Incentive payments that reward improvements in quality and innovation to focus on outcomes now make up a minimum of 2.5% of provider contracts, in order to encourage a focus on continuously improving the quality of services for patients. These payments (CQUIN), include a number of nationally mandated schemes aimed at improving safety and patient experience across the provider, for example the NHS Safety Thermometer, and improvements in the results of the patient survey.

1.21 The NHS Commissioning Board, with its statutory duty relating to improvement in quality, will continue to seek to create further incentives for providers to focus on the quality of services, learning from what has worked well and supporting local commissioners to develop effective quality incentives.

Extending the Statutory Role of Local Authorities

1.22 The Health and Social Care Act 2012 ('the 2012 Act'), gives local government three critical new roles in relation to health, enhancing and extending their previous role:

- leading on local public health;
- a strengthened leadership role in relation to the wider local health and social care system, through health and wellbeing boards; and
- putting in place a new consumer champion for health and care, local Healthwatch.

1.23 The Government has an ambitious programme to improve public health through strengthening local action, supporting self-esteem and behavioural changes, promoting healthy choices and changing the environment to support healthier lives by empowering local communities. Local Government (upper tier and unitary local authorities) will lead for public health because of its unique potential to transform outcomes for their local communities through:

- population focus;
- the ability to shape services to meet local needs; and
- the ability to influence the wider social determinants of health – such as housing and employment – to tackle health inequalities.

1.24 The 2012 Act also requires health and wellbeing boards to be established in every unitary and upper tier local authority area. Health and wellbeing boards will take an overview of health and care services, and they will guide action to promote population health and wellbeing. This strengthened leadership role for local authorities, working with the NHS and local communities, is intended both to improve outcomes and increase accountability and democratic involvement in health. Local Authorities will also be members of Quality Surveillance Groups.

Actions for Cultural Change

1.25 Throughout this response, we highlight case studies of things that NHS

Royal United Hospital Bath NHS Trust – *See it my way*
Using patient, carer and staff stories to inspire and motivate staff

"See it my way *sessions provide a time to re-connect with why we all work in the NHS – because we really care for people in need. Staff can see into the speaker's life and hear and feel the person behind the need and they are moved from within themselves to improve the way they interact and work*."

The Royal United Hospital Bath NHS Trust (RUH) has developed a powerful way of using patient stories to inspire and motivate staff. Regular events are held, open to all RUH staff at which patients, carers and staff are supported to talk about their experience of care.

Each event is themed around an area that has been identified as a priority for improving patient experience. Three patients, two carers and one member of staff speak to the audience. Speakers are chosen to be as diverse as possible, and to include stories from people who are often not heard or given a platform to speak, such as people with a learning disability, dementia or a terminal diagnosis. Patients, carers and staff who have spoken say they feel truly heard and valued by the experience.

Staff and patients at the RUH have been moved by the power of real life stories to inspire and motivate. As well as increasing their understanding and connection with the person behind the patient or role, staff have implemented practical changes following what they have heard.

To find out more see: www.ruh.nhs.uk/get_involved/ppi/index.asp

organisations are doing to build healthy organisational cultures. None of the methods and approaches described should be seen as a "silver bullet", but rather as part of a wider programme to drive change. The case studies throughout this document are offered to provide inspiration and prove what is possible, rather than offer a simple formula for transformation. Whilst the establishment of a Chief Inspector for Hospitals with a single clear picture of the quality of care for patients in each organisation will ensure a single set of incentives for hospitals, it will be for each board, each leader, each ward and each member of staff to find their own best way of achieving the best for patients. The Secretary of State for Health wrote to all hospitals at the time of the publication of the Inquiry report to ask leaders to reflect with their staff on the lessons to be learned from the Inquiry. It is this frontline reflection which will make sustainable change a reality.

Allied Health Professions – The Big Conversation

In February 2012, Karen Middleton, the Chief Health Professions Officer, met with leaders of the professional bodies, together with senior Allied Health Professionals (AHPs) leads from across the NHS to discuss professionalism. With evidence demonstrating that talking about an issue can shift the culture, the group agreed to stimulate frontline staff to have conversations about professional and unprofessional behaviour, the aim being to help develop a culture where clinicians feel as comfortable discussing values and behaviours with colleagues as they do discussing clinical issues.

AHPs were asked to consider '*What would you do if...?*' For example – if you saw a colleague texting while assessing a patient; or heard a colleague call a patient 'darling'; or saw a colleague rush treatment to finish work on time?

From this informal start, and active support from the key professional bodies, it has developed as a social movement among AHPs with discussions on professionalism in bulletins, journals and web sites, and cross-profession Twitter chats between AHP groups such as the occupational therapists (#OTalk) and nursing groups such as #WeNurses.

The importance of *The Big Conversation* is demonstrated through the many positive reflections of staff – *"we are being reminded daily that the small things make a big difference to the people we work with – both patients and colleagues."*

To find out more visit http://ahp.dh.gov.uk/category/professionalism-2/

Supporting Staff to Care

1.26 There is a wealth of evidence which shows clearly that the key to providing safe, effective and compassionate care to patients is supporting and valuing staff. Staff wellbeing is not just a matter of culture. It depends on tangible elements such as good management, effective job design, education, training and appropriate resources. But if boards and leaders do not engage the people they lead, through their own priorities and their own behaviour, in a common endeavour for the patients that they serve, then too often staff feel unsupported in their efforts to give their best for their patients. Board behaviour and leadership will be a key focus for the Chief Inspector of Hospitals.

The Emotional Labour of Care

1.27 Working in health and care is inherently emotionally demanding. To support staff to act consistently with openness and compassion, teams need to be given time and space to reflect on the challenging emotional impact of health and care work. Many organisations are already finding ways to do this, for example through Schwartz Center Rounds and Restorative Supervision (see boxes overleaf and in Chapter 5 respectively).

1.28 The National Institute for Health Research is launching a call for proposals for research to evaluate interventions aimed at increasing compassion and dignity in NHS care.

Schwartz Rounds at the Royal Free London NHS Foundation Trust

> *"It restores faith that you are working with colleagues who can share. There is a lot of angst and low morale in the health service but this shows there is heart here and we want to do the best for patients. It is quite uplifting."*

Schwartz Rounds have been held on a monthly basis at the Royal Free since October 2009. They are a forum for clinical and non-clinical staff from all backgrounds and all levels of an organisation to come together once a month, for one hour, eat lunch or breakfast together, and explore the significant impact that their job has on their feelings and emotions.

A team who have cared for a patient tell their story and this is followed by discussion, open to all, exploring issues that have arisen. It is not about problem solving – rather it is a dedicated time for reflection and a safe place to voice feelings not often shared, such as frustration, anger, guilt, sadness, joy, gratitude and pride. Joanna Goodrich, King's Fund fellow, says "*sitting in on Rounds all over the country I have been moved, time and again, by the commitment of staff, and humbled by their stories of how they have gone the extra mile for their patients – and seen what that has cost them*."

For more information on Schwartz Rounds, please see: http://www.kingsfund.org.uk/schwartzrounds

The Cultural Care Barometer

Many excellent tools have been developed to help teams and organisations measure their cultural health. The Cultural Care Barometer is one example, which Robert Francis highlighted in his report. Developed by the National Nursing Research Unit at King's College London in association with leading nurses from across the NHS, it aims to:

- be short and quick to complete;
- complement, not duplicate, other measures or quality programmes;
- allow "ward to board" communication;
- act as an early warning system to identify care culture problems; and
- prompt reflection, to help identify any actions required.

The tool is in the form of a short survey. However it is the **conversations** which the tool stimulates, for example through appraisal, which are important – both at team and board level.

The barometer is currently being piloted in an acute trust, and will be piloted in a range of other settings (including community and mental health services, and to test board effectiveness) before it will be ready for wider application.

Measuring Culture

1.29 Measuring culture is difficult, and needs to be approached with caution. Many tools exist to help organisations measure their culture – but no tool in itself is "the answer" – culture is easier "to smell" than it is to measure. What matters is *how* any tool is used, and what conversations take place on the basis of it. The new Chief Inspector of Hospitals, in making assessments of the culture of institutions to inform judgements about their ratings, will be dependent on the experience of expert inspectors with deep insight into how hospitals tick, supported by data about complaints, whistleblowing, patient experience and staff experience. Whilst indicators can be gamed, an experienced eye will be invaluable in ensuring that boards are showing the leadership needed to shape and enable positive cultures of compassionate care.

Creating Time to Care, Creating Time to Lead

1.30 The measures in this document – radical transparency, excellence in leadership, clarity of accountability, consequences for failure and rewards for the very best – will together put in place the measures needed to help revitalise the culture of the NHS around a consistent focus on the needs of the patients it serves. But to do so, leaders need time to lead and staff need time to care, unconstrained by a culture of bureaucratic compliance with national regulations. In a busier NHS, we will ensure that paperwork, box ticking and duplicatory regulation and information burdens are reduced by at least one third. With a single version of the truth in the Chief Inspector's balanced scorecard and assessment, there will be a single national portal – the Health and Social Care Information Centre – for collecting information, and it will have a duty to seek to reduce the information burden on the service year on year.

1.31 To support this, the NHS Confederation is undertaking a review of bureaucratic burdens on NHS providers. The initial focus of the review is to consider how to reduce the burden of inspection and data collection on the providers of care so that they can focus more on the delivery of safe, effective compassionate care. The review will report in full in September 2013 and Government will look carefully at how best to act on its findings.

1.32 The Health and Social Care Information Centre (HSCIC) collects and publishes comparable data on health and care to ensure that appropriate data standards are applied to that information. New provisions in the Health and Social Care Act 2012, coming into effect this April require that organisations across the health and care system must have regard to advice and guidance the HSCIC gives on data collection and the associated administrative burdens. Where an organisation does not comply, it must make public its reasons for not doing so. These arrangements will be strengthened to require organisations in the health and care system, including the NHS Commissioning Board, Monitor, the Care Quality Commission, Clinical Commissioning Groups and others, to comply with the HSCIC advice or guidance in certain circumstances. This may include, for example, where an organisation is seeking to carry out a new information collection itself, rather than draw on the resources already available to the system.

1.33 The Informatics Services Commissioning Group (ISCG), chaired by the NHS Commissioning Board on behalf of the health and care system, will ensure that the HSCIC becomes the focal point for data

collected at the national level, so the HSCIC becomes the 'gateway' for those seeking to collect new data. The ISCG will support the HSCIC in its duty to ensure that the burden on front-line services from data collection is significantly reduced.

1.34 Busy leaders and busy staff need to be freed up to build cultures of care and to care for patients. National and local bodies that impact on providers and staff will in future need to think hard and argue hard about why they need more information and consider its impact on direct care for patients. When information is collected, the technology needs to be in place to make it easy for organisations to provide and easy for frontline staff to collect, so they can concentrate on the patients that they serve.

1.35 The Government will implement in full the findings of the Fundamental Review of

NHS Confederation Review of Bureaucratic Burdens on NHS Providers: Interim Report Recommendations

1. Immediately implementing the Fundamental Review of Data Returns.
2. Developing an agreed single data set for all providers aligned around a single definition of quality that is appropriately balanced across the five outcome domains and has proper emphasis on the patient and public and frontline staff view of quality.
3. Placing requirements on regulators, commissioners, and providers themselves to use this as the single source of data to support multiple uses for regulation, inspection, licensing, quality surveillance and risk assessment, commissioning and benchmarking, quality reporting by organisations, and in time, research. This could include introducing powers to restrict organisations collecting their own data.
4. Establishing the new Health and Social Care Information Centre as a world-class data hub for all health and social care information and the single major collection point.
5. Creating a system of governance at the new Health and Social Care Information Centre that engages all the key stakeholder bodies (including representation from the NHS and patient groups) and establishes a robust process of continuous challenge about what is collected.
6. Requiring the new Health and Social Care Information Centre to consult and publish annually on the scope and volume of its required returns.
7. Creating incentives on all organisations in the NHS to minimise locally driven information collections, subject to the proper management and assessment of risk.
8. Increasing and facilitating information sharing across all organisations concerned with NHS and social care to minimise duplication of data collection and underpin a safer process of integrated care for patients.
9. Creating an effective and transparent system of earned autonomy to guide the volume and frequency of external assurance and inspection activity by regulators.
10. Committing wholeheartedly to the roll-out of digital technology to reduce the burden on frontline staff collecting information by incentivising procurement and deployment of digital collection systems.

Data Returns, carried out by Department of Health and the HSCIC in partnership with key organisations who generate or use NHS data. Fifty-eight data returns have already been suspended and work will start immediately with the owners of data returns to discontinue any remaining redundant data returns. This will deliver a 25% reduction in the number of data returns that NHS organisations are required to send to the Department of Health and its arms length bodies, freeing up time for hospital boards and staff to focus on providing high quality, compassionate care.

1.36 Drawing on the HSCIC, the NHS Commissioning Board is leading work to build a modern data service, ***care.data***, in health and social care, to provide timely and accurate data derived from information collected as part of the care process and linked along care pathways.

Safety in the DNA of the NHS – The Berwick Review

Zero Harm

1.37 A critical component of NHS culture must be a deeply embedded culture of safety. Whenever avoidable harm or deaths occur, these need to be treated on every occasion as an individual disaster, requiring close

NHS Safety Thermometer
Monitoring the Safety of Care at the Frontline and Taking Action to Improve

The NHS Safety Thermometer is the first tool to measure four high volume patient safety problems – pressure ulcers; falls in care; urinary infection (in patients with a urinary catheter); and treatment for new Venous Thromboembolism (VTE).

It can be used across a range of settings, including for district nursing caseloads, in community hospitals, in nursing homes as well as in acute care. It gives immediate feedback for teams to use in their improvement work and the data collected can be viewed at the ward, organisation or national level at the push of a button. The NHS Safety Thermometer gives nurses on the front line the power to take control and make the NHS a much safer place for patients. It only takes a few minutes to complete the checklist, it can be completed as part of routine care and can save a significant amount of staff time as it means they don't have to deal with as many preventable patient safety incidents.

The tool is called the NHS Safety Thermometer because it is used to take the temperature of safety in an organisation, caseload or ward. It takes only a minimum set of data that helps to signal where individuals, teams and organisations might need to focus more detailed measurement, training and improvement. Just like a regular thermometer it can flag abnormal readings and measure changes. The power of the NHS Safety Thermometer lies in it being used by frontline teams to measure how safe their services are and to really deliver improvement locally.

Use of the NHS Safety Thermometer is incentivised across the NHS through the existence of a 'CQUIN' (Commissioning for Quality and Innovation) payment. It is being adopted rapidly across the NHS with virtually all of the health care organisations in some areas using the tool.

scrutiny, deep learning and lasting change. A "never event" must become a "never again" event for every NHS organisation. A "these things happen, let's move on" approach is unacceptable in 21st century care and is unacceptable to patients.

1.38 Safe care is about both systems and people: ensuring organisational structures, policies, procedures and practices are delivering reliably safe care (such as computerised prescribing to reduce medication errors or the NHS Safety Barometer – see box); and ensuring that staff's decisions and behaviours and the effect of these are promoting safer care and avoiding risk and harm. It is about minimising harm without creating a risk-averse environment where fear overrides sensible decision-making. Health and care is inherently a risky business and many of the most important developments in improving medical care have relied on clinicians being willing to break new ground and innovate.

1.39 At Mid Staffordshire NHS Foundation Trust, patients were not receiving reliably safe care and treatment. The report cites many factors that demonstrated a systemic failure at the hospital. This included compromised staffing levels, poor nursing handover, disempowerment of medical and nursing staff, poor clinical governance (including poor systems for managing serious untoward incidents and not implementing national patient safety alerts) and a failure, or even a refusal to listen to staff and patients when they had concerns. The wider system failed to detect the risks to patients at the hospital and intervene quickly.

1.40 The Government has asked Don Berwick to lead a National Patient Safety Advisory Group to advise on a whole system approach to make zero harm a reality in the NHS, reporting by the end of July. The Group will reflect on the findings of Robert Francis' report in relation to the quality and safety of patients and propose a new improvement programme that will build capacity and capability for safety in the NHS. The Group will also advise on how to bring about a genuine culture of change in the NHS so that staff at every level and across the entire healthcare system can take serious and profound action to make patient care and treatment as safe as it can possibly be.

1.41 Following the Berwick Review, the Department of Health, the NHS Commissioning Board and the Care Quality Commission will jointly consider the recommendations and work with other stakeholders to agree the key roles and responsibilities for patient safety across the healthcare system. Its findings will have deep significance for the future of our healthcare system, the safety of care and public and patient confidence in the NHS.

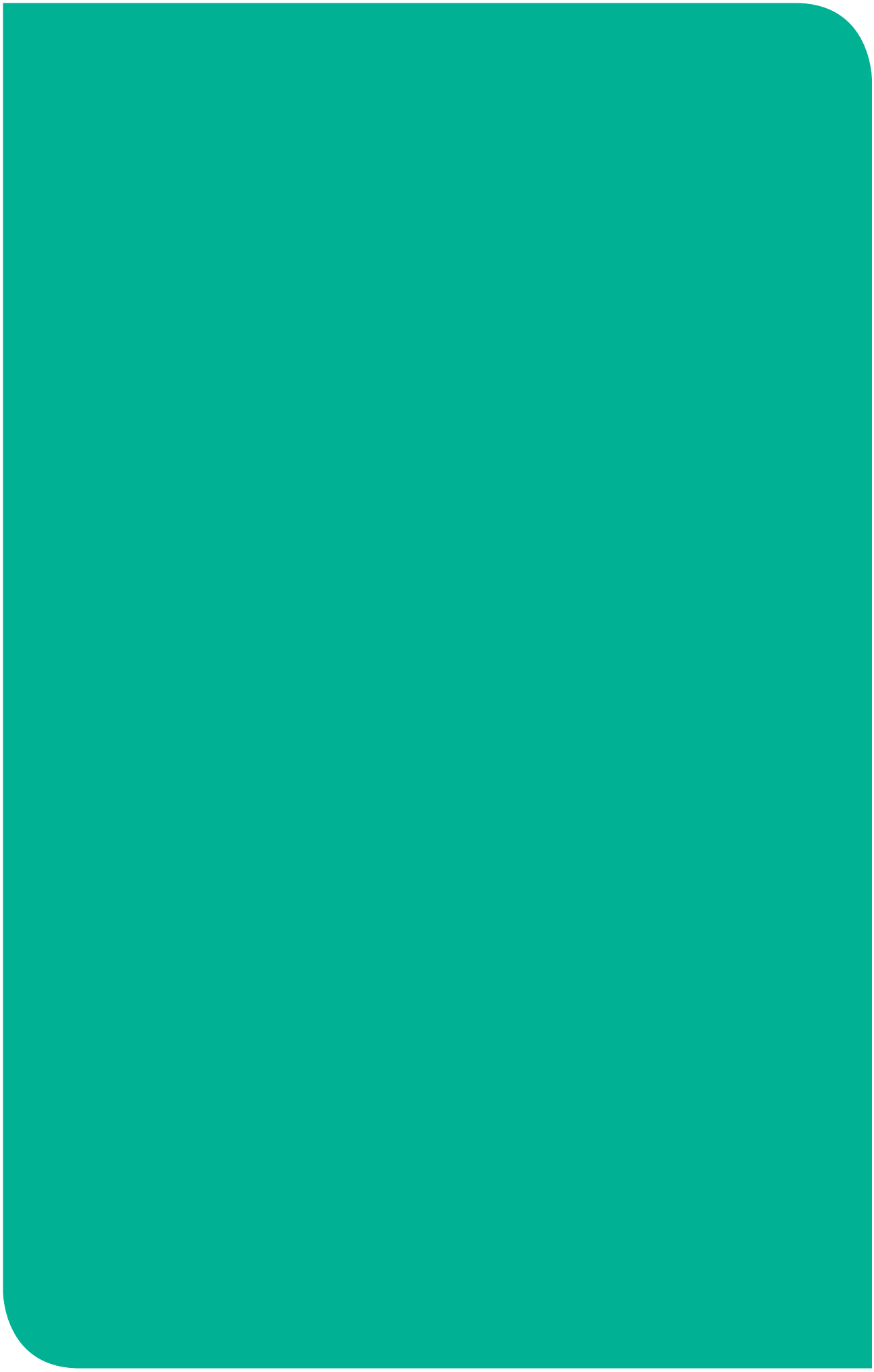
1.42 From 2012 the mechanism by which patient safety incidents are reported nationally transferred to the NHS Commissioning Board. This data is used to derive learning from patterns and trends in incidents to prevent future harm. The NHS Commissioning Board will develop and deliver a revised, easy-to-use and responsive National Reporting and Learning System (NRLS) that will provide a "one-stop shop" for the NHS, clinicians, patients and the public to report patient safety incidents and receive advice. It was Robert Francis' recommendation that the functions of the National Patient Safety Agency were transferred from the NHS Commissioning Board to the Care Quality Commission. However, given that the NRLS was only transferred to the NHS Commissioning Board in 2012, the Department believes that reallocating this work at this stage would be unnecessarily disruptive. There are already good information flows from the NRLS to the Care Quality Commission, which are analysed and brought

to inspectors' attention through the Quality Risk Profile (QRP) to support their planning of inspections. In addition, the functions transferred to the NHS Commissioning Board go further than the remit of the Care Quality Commission at this time. We will, however, keep this under review.

1.43 Given the importance of the medical profession to good care, the General Medical Council (GMC) has an important part to play in shaping the culture of a system in which doctors' behaviour and values are so vital. It has issued new guidance on leadership and management for all doctors which was sent to every doctor in the United Kingdom, saying that all doctors, whatever their role, must raise and act on concerns about patient safety. It also makes clear that doctors must not sign contracts that attempt to prevent them from raising concerns with professional regulators, nor must doctors in management roles promote such contracts or encourage other doctors to sign them. The Government expects other professional regulators to embrace this approach, as many are already doing.

Conclusion

1.44 The changes to inspection, regulatory and information burdens, transparency and accountability set out in this response will themselves help to shape a more consistently safe, effective, respectful and compassionate culture in our NHS, and these principles extend beyond health to the care system. But to be sustainable they need to change the behaviour of boards, leaders, and staff. Many already embrace this culture, but have been hampered by national targets, bureaucracy and a lack of time to care and a lack of time to lead. The Government is determined to address this, but for real to change to occur, local staff and local leaders must embrace the need for fundamental change. As Robert Francis has said repeatedly, the NHS and its dedicated staff do not need to wait for Government to legislate, or guidance from national bodies: we urge everyone at the frontline of care to have confidence in their caring, professional NHS values and take to their hearts the hard task of changing care for the patients that they care so deeply about. The Government will do everything in its power to support them.



Chapter Two – Detecting Problems Quickly

Summary

The Care Quality Commission will appoint a powerful Chief Inspector of Hospitals later this year. Informed by expert judgements of inspectors, the Chief Inspector will make an assessment of every NHS hospital's performance.

Using expert-led inspections, the Chief Inspector will shine a light on how our hospitals are serving patients. Just as OFSTED acts as a credible, respected and independent arbiter of the best and the worst in our schools, the Chief Inspector will become the nation's whistleblower – naming poor care without fear or favour, from politicians, institutional vested interests or a loyalty to the system rather than the patients that it serves.

The Chief Inspector will ensure that there is a single version of the truth about how hospitals are performing, not just on finance and targets, but in a single assessment that reflects what is important to patients. As in education, the Chief Inspector will make a balanced assessment of whether hospitals are in categories such as "outstanding", "good", "requiring improvement" or "poor". Outstanding hospitals will be given greater freedom from regulatory bureaucracy. The Friends and Family Test for both staff and patients will be a vital component part of the rating.

A new spirit of candour and transparency will be essential for exposing poor care. As the publication of individual outcomes for heart surgery has helped to drive up standards in that field, the NHS will extend this openness on outcomes to further specialties.

Mortality data must be interpreted with care, but it must also be accurate so that the public and patients can trust that they are hearing the truth. So there will be tough penalties and possibly criminal sanctions on organisations that are found to be massaging figures or concealing the truth about their performance. A statutory duty of candour will reinforce the existing contractual duty, so that patients can be assured that they are given the plain truth about the care that a hospital provides.

Clauses intended to prevent public interest disclosure by NHS staff will come to a halt. Staff who speak up about problems should be supported, not vilified.

A review of best practice on complaints will 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.

Introduction

2.1 The measures set out in Chapter One will help to foster a more consistent culture of safe, effective, respectful and compassionate care for patients and thereby help prevent problems from arising. But in a system as important to the public and to individual patients as the NHS, there also needs to be a robust and effective system to provide ongoing surveillance and proportionate inspection to spot problems so that action can be taken to address them effectively and promptly.

A Chief Inspector of Hospitals

2.2 The Care Quality Commission will become the primary assessor of quality in the health and social care system. The Chief Inspector of Hospitals will be the focal point for honest and independent assessment about how well or badly hospitals are serving patients and the public. To avoid duplication this will mean change to the existing quality surveillance responsibilities of Monitor and the NHS Trust Development Authority. This means that the focus for the Care Quality Commission will widen from being merely a regulator of compliance to becoming an inspector of quality.

2.3 In delivering this role, the Care Quality Commission will develop a method of assessing the overall performance of organisations in meeting the needs of patients and the public. To ensure that all national organisations are sending a single measure of success to the system, the Care Quality Commission will agree this with Monitor, the NHS Trust Development Authority and the NHS Commissioning Board. Building on the work of Lord Darzi, there will be one agreed national definition of quality. The method will be consistent with the Mandate to the NHS Commissioning Board and the NHS Outcomes Framework set by Government, and its application will also take account of the need to reflect local commissioner priorities. When assessing individual providers, the Care Quality Commission will look at quality in the round, not just registration standards. While in the past a plethora of signals and imperatives left providers pulled in conflicting directions about what was really expected of them, in future there will be a clear, single nationally agreed definition of success, a single assessment of achievement against that and no room for manoeuvre locally of playing one national supervisory body off against another.

2.4 The Care Quality Commission, the NHS Commissioning Board, Monitor and the NHS Trust Development Authority will be required to agree together the data and methodology for assessing hospitals. This will ensure a single set of expectations on hospitals of what is required of them that is aligned with the way in which commissioners, led by clinicians and guided by the views of local patients, ensure high quality care in the hospitals for which they are responsible. Providers will demonstrate, through annual Quality Accounts, how well they are meeting that single set of expectations.

2.5 In line with its clearer leadership on quality assessment and surveillance, the Care Quality Commission will over time lead on the assessment aspects of local Quality Surveillance Groups and local Risk Summits, and the NHS Trust Development Authority and Monitor will lead on enforcement. The Chief Inspector will become the leader in the system that coordinates national bodies for a single set of quality expectations, a single assessment of performance against them and ensuring that nationally and locally everyone works together to detect poor care and ensure appropriate action is taken.

2.6 For NHS trusts and foundation trusts, to reduce duplication, the Chief Inspector will focus on exposing problems and requiring action, with enforcement action overseen by Monitor for Foundation Trusts or the NHS Trust Development Authority for NHS trusts. In line with that, the Care Quality Commission will formally delegate its enforcement powers (those beyond warnings) to Monitor and the NHS Trust Development Authority. We will ensure Monitor retains sufficient powers of Foundation Trust oversight. We will discuss with the three bodies concerned the detailed practical arrangements for this.

2.7 For the time being, the Care Quality Commission will retain all its current enforcement powers for social care, general practice, social enterprises and independent sector providers. However, we recognise fully the differences between health and social care provision, we will look carefully at the options for enforcement, either by the Care Quality Commission or other bodies, in the same way as we are doing for hospitals.

Chief Inspectors

2.8 The new Chief Inspector of Hospitals will take the lead across the system on assessing the quality of care in hospitals. The Chief Inspector will provide oversight to the Care Quality Commission's inspections, assessments and ratings of providers, identifying both good and poor performance. He or she will communicate these findings to the public.

2.9 Robert Francis stressed the importance of physical inspections. The Chief Inspector will lead an expert team that conducts inspections and actively engages with other organisations including Monitor, the NHS Trust Development Authority and the NHS Commissioning Board as a pivotal part of the single failure regime and the national ratings for hospitals.

2.10 We will also consider whether there should also be a Chief Inspector of Primary Care, with the Care Quality Commission consulting with the public, patients, health professionals, commissioners and others on whether the broad approach which applies to hospitals could be extended to primary and community services. In doing so it will be important to ensure that the new inspection regime reduces regulatory burdens whilst enhancing public confidence and builds on the role of Clinical Commissioning Groups in driving up the quality of primary care.

Expert Inspectors

2.11 As with clinical practice, inspection is both a science and an art, based on knowledge, experience and judgement. To have authority and credibility, inspection must be led by individuals with deep insight and specialist experience in the areas for which they are responsible, with the close involvement of patients, staff and others. The new Care Quality Commission leadership is developing a model of inspection that will secure thorough and insightful inspections which combine first-hand expert experience with data and feedback from patients and staff. The Care Quality Commission will set out their proposals in their new strategy in more detail shortly.

Ratings – A Single Balanced Version of the Truth

2.12 We intend to give the Care Quality Commission the power to conduct ratings at the earliest opportunity and we will work with the Nuffield Trust to develop these proposals further. Whilst there is a significant amount of information available on organisations

providing health and social care in England, there is currently no aggregated rating to summarise and compare the performance of organisations or the services provided by them. Just as OFSTED offers clear reports on local schools, a new regime is needed to give patients and the public a fair, balanced and easy to understand assessment of how well a provider is doing relative to its peers.

2.13 To this end, the Secretary of State for Health commissioned the Nuffield Trust to carry out an independent review of whether an aggregate rating of provider performance should be used in health and social care, and if so how best this might be done. The Nuffield Trust report, *Rating Providers for quality: a policy worth pursing?*[7], published last week, has set out advice on an aggregate rating for GP practices, hospitals and care homes based on information that matters to patients and service users. It suggests an overall approach to ratings that allows complex organisations, particularly hospitals, to be assessed not just at an organisational level, which could be misleading on its own, but at different levels with service-specific ratings where possible. While a range of commercial organisations currently offer benchmarking data or provider ratings, the report highlights a clear place for an aggregate rating based on inspection as well as data. In the light of this advice, aggregate ratings will be developed and published by the Care Quality Commission, independently of Government. The Care Quality Commission will also work with Monitor, the NHS Trust Development Authority and the NHS Commissioning Board to agree an overall approach to provider assessment, which will aim to minimise duplication, reduce burdens and join-up intelligence.

2.14 Aggregated ratings of provider performance will be of value to the public in helping to choose the right services, and to those organisations providing or purchasing services to seek better performance. Subject to the conditions outlined in the Nuffield Trust report regarding larger and more complex organisations, which we accept, ratings will be compiled using both judgement and data to ensure there is a system wide 'single version of the truth'. Award of the bottom category rating in itself will automatically trigger action. We will work with the Care Quality Commission and the Nuffield Trust to develop these proposals further.

2.15 The Department of Health will commission an independent evaluation of the operation of the new ratings system, and this will inform future adaptations. Subject to the findings of the evaluation, changes will be kept to the minimum necessary, to provide stability for providers and facilitate meaningful comparison over time.

Working Together to Focus on Quality

2.16 The National Quality Board (NQB), established in 2009, brings together the national organisations tasked with safeguarding and improving quality. Following the publication of the first Inquiry into Mid Staffordshire NHS Foundation Trust, the NQB published a *Review of early warning systems in the NHS*[8] and *Quality in the New Health System*[9] that began to assess how systems, values and behaviours could better support the detection and prevention of serious failures against basic standards.

2.17 From April 2013, a network of local and regional Quality Surveillance Groups (QSGs) will bring together commissioners, regulators, local Healthwatch representatives and other bodies on a regular basis to share information and intelligence about quality across the system, including the views of patients and the public, and proactively spot potential problems early on. QSGs will

be supported and facilitated by the NHS Commissioning Board and will foster a culture of open and honest cooperation. This will support many of the recommendations made by Robert Francis in relation to the sharing of information. They will also help support the coordination of any action that is needed to respond where risks to patients are identified. Over time, as the Chief Inspector role becomes established, the Care Quality Commission will assume a leading role in these quality oversight and surveillance arrangements.

2.18 Where concerns arise of a serious failure, members of the QSGs will be able to act quickly by triggering a "risk summit". All QSG members relevant to the provider in question attend these summits so that they can, together, give specific, focussed consideration to the concerns raised and develop a joined-up response. In Autumn 2013, the National Quality Board will review how the QSGs have worked, taking into account relevant recommendations made by Robert Francis, and update guidance to ensure that all QSGs can learn from best practice.

2.19 We need to do more to ensure effective joint working, including with coroners, building on the recommendations about better information sharing. Monitor and the Care Quality Commission have reviewed their working arrangements to ensure that they work better together to share information about the performance of foundation trusts. The Care Quality Commission already receive many of the rule 43 reports which are issued where a coroner believes that action should be taken to reduce the risk of future deaths. However, the Chief Coroner will issue guidance to Coroners Offices, as recommended by Robert Francis, to promote the sharing of these reports with the Care Quality Commission and its Chief Inspectors.

Care and Support

2.20 In care and support, the system will apply the same lessons to ensure problems are identified early and resolved quickly. Providers of care have the primary accountability for the quality of the care people experience, but commissioners and the regulators have important roles to play, as set out in *Bringing Clarity to Quality.*[10] From April 2013, NHS Choices will include new care and support information, including online public comments to compare care from different providers. This will include the ability to submit and view comments from users and their families giving the public greater transparency of people's experiences of care, and giving providers the chance to act on what they hear.

2.21 Local authority commissioners of care are leading the drive to improve the quality of the care and support they provide for their communities. The *Towards Excellence in Adult Social Care* programme, led by the local government sector, combines strengthened transparency on councils' performance with a robust programme of peer-to-peer challenge and review, supporting councils to identify and act upon areas of concern. A key focus of the programme has been to enhance the information available both to councils, to support their improvement efforts, and to local people, making councils genuinely answerable to the people they serve. Currently, available information on councils' performance is being used to good effect, with most local authorities already publishing local accounts, which set out councils' progress and priorities, supporting an active dialogue with local communities on performance. The Care Quality Commission will want to review these arrangements in discussion with key partners when the Chief Inspector of Social Care is appointed.

University Hospital of North Staffordshire – Proud to Care

North Staffordshire have worked hard to embed a safety and quality culture. One aspect of their *Proud to Care* programme is the use of patient stories to inspire staff. Stories of excellent patient-centred care are highlighted in a regular staff bulletin.

One story is about Margaret, 74, who had recently lost both her husband and daughter to cancer. Margaret needed a blood transfusion but felt unable to attend her appointment, which was in the same building where her daughter had been treated. Hospital staff tried hard to arrange for Margaret's appointment to take place in a community setting, but due to the specialist equipment needed, it was not possible.

On the day of the transfusion, a dedicated nurse met her at the entrance of the building to help her overcome her anxiety, and cared for her throughout the day. The Matron also spent some time talking to Margaret to ensure her needs were met. Staff ensured that Margaret was not left alone, and received the emotional support she needed during this difficult time.

Following her treatment, Margaret specifically asked to speak to the Matron to praise the team and pass on her thanks to all involved.

For more information, please see http://www.uhns.nhs.uk/ForPatients/ProudtoCare.aspx

Transparency

2.22 The Government's mandate[11] to the NHS Commissioning Board set an objective to shine a light on variation and unacceptable practice, to inspire and help people to learn from the best. The Government wants to see a revolution in transparency – so that the NHS leads the world in the availability of information about the quality of services. From 2015, the NHS Commissioning Board will ensure that data on services at speciality level is increasingly available. To do this they will work with providers, patient groups, speciality level organisations and those bodies such as the Health and Social Care Information Centre and the Care Quality Commission that have an interest in the collection, use and publication of such data. As the publication of individual outcomes for heart surgery has driven up standards in that field of medicine, as a starting point, the NHS will extend this openness on outcomes to cardiology, vascular surgery, upper gastro intestinal surgery, colorectal surgery, orthopaedic surgery, bariatric surgery, urological surgery, head and neck surgery and thyroid and endocrine surgery.

2.23 All hospitals are required to produce Quality Accounts, an annual statement of their performance on quality with the same importance as annual financial accounts. From April 2013, Quality Accounts will also include comparable data from a set of quality indicators linked to the NHS Outcomes Framework. This will include the summary hospital-level mortality indicator, infection rates and levels of patient safety incidents. Quality Accounts are already made available to the lead commissioner, Overview and Scrutiny Committees and local Healthwatch organisations prior to publication. Any comments that these organisations make must be included in the Quality Account. The Department of Health will lead work on

further standardising quality accounts to increase their impact and reduce burdens.

2.24 Complaints information, along with comments and feedback, is also a key part of ensuring the quality of services provided by NHS providers. In February 2013, the Department announced that a review of complaints would be undertaken this year. It would include how the information from complaints is shared and used to protect patients. It will report in the summer.

Mortality indicators

2.25 Since October 2011, the Health and Social Care Information Centre has published as an experimental national statistic, the Summary Hospital-level Mortality Indicator (SHMI). This followed from a review in 2010 of Hospital Standardised Mortality Ratios (HSMR) in response to the publication of the first Inquiry[12] SHMI data can be used by trusts, as part of a wider set of information that identifies risks to patients, to review performance and consider where action may need to be taken to protect patients.

2.26 Professor Sir Bruce Keogh is investigating the quality of care and treatment provided by those NHS trusts and foundation trusts that are persistent outliers on mortality indicators. The investigation will look at 14 trusts that have been outliers for the last two consecutive years on either the SHMI or the HSMR. The investigation will seek to determine whether there are sustained failings in the quality of care and, where there are, if actions already taken by these trusts are sufficient or whether further support or regulatory action is required to protect patients. The review will report by the end of summer 2013.

Quality and Risk Profiles

2.27 The Care Quality Commission has developed Quality and Risk Profiles (QRP) as its main information tool to support its inspectors to target their inspection activities. The profiles draw together and analyse information from a wide range of internal and external data sources. To ensure that the Care Quality Commission is focusing on the things that matter most for the different settings that it regulates, it has commenced a major piece of work to develop the way in which it uses and analyses information. This work will be used to identify, predict and respond to varying standards of care and will help drive the Care Quality Commission's new inspection methodology. The Chief Inspector and the Care Quality Commission will review how this sits within the overall surveillance systems set out in this document.

2.28 The Department of Health and the Care Quality Commission will look at ways to make their analyses about standards of care publicly available (and the methodologies used) as recommended by Robert Francis. This will allow patients to be better informed about risks to the outcomes of their care and treatment.

Duty of Candour

2.29 A spirit of candour will be critical to ensuring that problems are identified quickly and dealt with promptly. Openness is a key element of healthy organisational cultures in health. There is a requirement to be open in the professional codes of practice for managers, doctors and nurses and the principles are also covered in the NHS Constitution and the Care Quality Commission's guidance. In addition to clinicians and other health and care professionals, it is also the responsibility of boards and leaders in provider organisations

to support openness and deliver high quality care. Clear guidance exists on how to disclose patient safety incidents to patients in the form of *Being Open*[13] published by the National Patient Safety Agency in 2010.

2.30 Patients also need proper advocates. They can help patients when things go wrong but they are also part of a system that provides support to patients, particularly vulnerable patients, when they need assistance. Advocacy is being considered as part of the review of complaints.

2.31 The NHS Standard Contract for 2013/14 will include a contractual duty of candour on all providers to be open and honest with patients when things go wrong with penalties for breaching the duty. The rationale for a contractual duty is that individual clinical commissioning groups (as opposed to a single national body) are best placed to examine their own local providers and take action where required. A contractual duty placed upon organisations is also the best approach for encouraging staff to be open and report incidents, and thereby promote a positive safety culture. This is because the onus is on the organisation to create a supportive culture in which people can admit mistakes – a challenging, but nonetheless essential task when it involves a needlessly injured patient or relatives who have been bereaved.

2.32 We intend to go further and introduce a statutory duty of candour on health and care providers to inform people if they believe treatment or care has caused death or serious injury, and to provide an explanation. We will need to carefully consider the scope of this duty on all providers. We will also work closely with professional regulators to examine what more can be done to encourage professionals to be candid with their patients at all times.

Criminal Sanctions

2.33 Robert Francis' report makes a number of recommendations in relation to the use of criminal sanctions when things go wrong, or where there is wilful misleading of the public or regulators by individuals. We recognise that attaching criminal sanctions to key areas of public service delivery can send an important message about the expected standards of care and duty to the public. However, before we introduce criminal sanctions at an individual level for staff providing NHS services we would want to ensure that this does not unintentionally create a culture of fear. This in turn could prevent lessons being learned and could make services less safe. However, we agree that in the unusual situation where staff deliberately allow fundamental standards to be breached or are obstructively dishonest, robust action should be taken. We will consider the conclusions of Don Berwick's review of safety and what further action might be taken by the Nursing and Midwifery Council, the General Medical Council and other professional regulators before deciding on the appropriateness of criminal sanctions below board level. We will also review whether existing criminal sanctions could be applied more effectively.

2.34 There can be no excuse for boards who knowingly supply wrong information about key indicators such as mortality rates, or deliberately withhold information from patients or families about serious harm or death. So where organisations wilfully generate misleading information or withhold information they are required to provide, we will consider the introduction of additional legal sanctions at a corporate level.

A Ban on Clauses Intended to Prevent Public Interest Disclosures

2.35 Robert Francis makes clear the important role that whistleblowers played in uncovering the events at Mid Staffordshire NHS Foundation Trust but also highlighted the challenges they faced being heard and believed. He recommended that any 'gagging clause' that seeks to limit legitimate disclosure of problems with patient safety and care should be prohibited.

2.36 Contracts of employment and severance are determined between the employing organisation and its employee. We acknowledge that the use of confidentiality clauses within compromise agreements has a right and proper place, to ensure that both parties end the employment with a clean break. We have consistently made clear that where confidentiality clauses are used, they should go no further than is necessary to protect matters such as patient confidentiality and commercial interest. Under no circumstances should clauses ever seek to prevent the departing employee from making a disclosure in the public interest. In practice, all such clauses are unenforceable in law. We are clamping down to make sure that the law is observed.

2.37 The Secretary of State for Health wrote to all Trusts on 15 February 2013 reminding them again of their obligations to have Public Information Disclosure Act (PIDA) compliant whistleblowing policies and asking that they '*check that the confidentiality clauses in your contracts (and compromise agreements with departing employees) do indeed embrace the spirit of [this] guidance. I would also ask you to pay very serious heed to the warning from Mid Staffordshire that a culture which is legalistic and defensive in responding to reasonable challenges and concerns can all too easily permit the persistence of poor and unacceptable care.*'

2.38 The Secretary of State for Health has announced that the era of gagging NHS staff from raising their real worries about patient care must come to an end. Staff who show the professionalism and personal courage to speak out in the public interest – which is difficult even in an open culture – must be celebrated and rewarded, even if, following investigation the concern turns out to be misplaced.

2.39 We will update our guidance to make clear that any compromise agreements must include an explicit statement making clear that '*nothing within the agreement prevents the parties from making a protected disclosure in the public interest*'.

2.40 The Government has already taken a series of steps to enhance the protections available to whistleblowers – including a right to raise concerns within staff contracts; amending the NHS Constitution to include explicit rights and pledges on whistleblowing; issuing new guidance to employers; and extending the national helpline to include staff in social care settings for the first time. In addition, the annual NHS Staff Survey asks staff if they are aware of how to raise a concern, if they feel safe to do so and if they believe their organisation would take action on a concern. Responses to the questions can be broken down by trust, professional and demographic group, allowing benchmarking of performance. All staff survey data is publicly available.

2.41 Those changes mean that NHS staff have professional duties and contractual rights to raise concerns and, if need be, to whistleblow where they believe that the basic standards of quality of patient care are not being met. The NHS Constitution contains a corresponding pledge that Trusts and other providers of NHS services will actively

Whistleblowing: Advice to all NHS Staff (extract from NHS Constitution Handbook 2012 edition)

- If you have a concern about a risk, malpractice or wrongdoing at work, you should normally raise it first in confidence with your line manager or lead clinician, either verbally or in writing if you are able to do so.
- If you feel unable to do this, you may raise it with the designated officer within your employing organisation. You should find details of the designated officer in your employer's whistleblowing policy.
- If you have raised your concern with the designated officer or your line manager, but feel it has not been addressed properly, or that inadequate action has been taken, you should raise your concern via the dedicated whistleblowing helpline which provides a free, independent and confidential service, staffed by legal experts, which can support staff who need advice. The freephone helpline number is **08000 724 725**.
- If your concern is related to a detected or suspected incidence of fraud or corruption, you should follow your local whistleblowing policy or the reporting procedure prescribed by NHS Protect by reporting directly to the Local Counter Fraud Specialist, Director of Finance, or via the fraud and corruption line or online reporting form where you are able to. You will still be entitled to make a whistleblowing complaint and receive protection under the Public Interest Disclosure Act.
- In certain circumstances, wider disclosures to bodies or persons other than your employer or a Minister of the Crown may also be protected by PIDA. A number of additional tests (aside from reasonable belief and good faith) will apply to assess whether such a disclosure is a "protected disclosure". Those additional tests will vary from case to case and may include consideration of the following factors:
    - the identity of the body/person to whom the disclosure is made (generally disclosures to the media are unlikely to be covered), and the seriousness of the alleged breach and whether it is "an exceptionally serious" concern;
    - there is a risk that evidence could be destroyed or concealed if the disclosure is made to the employer or another prescribed person;
    - the disclosure amounts to a breach of confidence with the employer;
    - the matter has already been raised
    - there is a good reason to believe that the individual will be the subject of a detriment by their employer if the matter were raised internally or with another prescribed person; and
    - disclosure was reasonable given the circumstances.

Staff considering such a disclosure are advised to take advice from the helpline, their trade union or their regulatory body before taking this step

Florence Nightingale School of Nursing and Midwifery, Kings College London Research – Experience-based co-design

> "*We were all together. There was that terrific sense of an equal playing field. Anybody could speak. There was no sense of fear, there was no hanging on status or using it. It was quite incredible really*."

Experience-based co-design (EBCD) uses the experiences of patients, carers and staff to redesign all or part of a particular health care process, to make it more efficient, safe and a better overall experience for both patients and staff.

EBCD starts by filming patients telling their stories and carrying out observation of routine care, to help staff to '*see the person in the patient'*. Patients and staff then sit down and redesign services together, the focus being on designing the human experience and not just impersonal systems or processes.

Research shows the approach can lead to:

- practical, tangible quality improvements felt by patients and staff
- a significant legacy in terms of patient-centred working, support groups, and information for patients
- cultural change, for example, greater and more open team working and better communication across departments, clinicians and staff of different grades.

> "*I have done lots of surveys and I often feel that my experience isn't reflected on there. I want to tick a box that's not there. EBCD gave me, as a patient, a chance to say what was actually happening*"

Experience-based Co-design toolkit: http://www.kingsfund.org.uk/ebcd/

support them by promoting a culture where the raising of concerns is valued as a means of improving the quality of care.

2.42 The Government has agreed an amendment to the Enterprise and Regulatory Reform Bill, securing Public Interest Disclosure Act (PIDA) protections for all NHS staff by adding other NHS contractual arrangements to the extended definition of "worker" in section 43K of the Employment Rights Act 1996. We have recently welcomed proposals from the Department for Business Innovation and Skills to introduce vicarious liability into employment law to provide even greater whistleblower protections. This means that if staff who raise concerns about poor care are harassed by their colleagues, their employer is liable for this conduct.

The Friends and Family Test in NHS Midlands and East

Since April 2012, providers in NHS Midlands and East cluster have been piloting a friends and family question as part of their feedback mechanisms, and the lessons and experience from this pilot area has fed substantially into the development of the national Friends and Family test.

It has had considerable impact in the Midlands and East area as local teams have embraced the opportunity to hear feedback from their patients, in better time than is currently provided by existing national survey mechanisms. It has led to local changes being implemented on a practical level for patients, and has increased ownership of the patient experience from ward staff, who are now keen to see the latest weekly scores.

For more information read, *The Patient Revolution: The continuing journey from across the Midlands and East*. See http://www.strategicprojectseoe.co.uk/uploads/FNL%20-%20Patient%20Revolution%20Continuing%20Journey%20Feb%202013(1).pdf

2.43 We have considered with regulators and staff the need for an independent authority to which staff could turn when their own organisation is not listening alongside the wider recommendations made by Robert Francis. The Care Quality Commission has considerably improved its service since 2010, and the new process includes a "track and trace" team to ensure no concerns get lost in the system. We will therefore not be creating a new body, but will work to ensure all organisations work together to learn from whistleblowers and make sure that action is taken when people raise concerns.

Engaging and Involving patients

2.44 A key theme running through the Francis Report was the observation that patients, their carers and families were not listened to during and after their care. The reason for this is not something that can be changed through an organisational restructure but is one of culture – listening to patients, their carers and families, considering and responding to their views, and treating patients as equal partners in decisions about their treatment and care. This is a particular concern for older people and other groups whose voice can sometimes be harder to hear and where we need to listen more carefully.

2.45 The care system requires a genuine shift to placing patients at the centre, shaping services around people and their preferences, involving them at all stages of service delivery from assessing population needs to commissioning and service design to patient feedback. In the future patient feedback and information on patient experience will be an even more important influence on shaping policy and the delivery and regulation of care services. Involving people in decisions about their health, care and services should be the norm, not the exception.

2.46 All key organisations within the health and care system need to ensure that they are listening to and understand the views of people who have experience of using the NHS and care services so that the work they do is properly informed by the voice of patients and citizens.

2.47 The Department of Health will ensure that it connects with the voice of patients,

Northumbria Healthcare NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust has some of the most satisfied staff and patients in England and firmly believes the two must go hand in hand for a healthy organisational culture.

Staff are listened to, empowered to instigate change and own quality improvements with support from the very top of the organisation. The Trust recruits staff based on values, attitudes and behaviours, as well as skills and expertise, and invests heavily in nurturing its staff – which means leaders are born at all levels of the organisation, rather than relying on old fashioned hierarchies. The Trust was one of the first in England to appoint a Director of Patient Experience at Board level and they run an award winning patient experience programme. Feedback from patients is shared openly within 24 hours of receipt – not to judge or criticise – but to initiate change and encourage teams to lead improvements and foster a positive mindset to make things even better.

Every month, a patient and their family come and tell their story at start of the Trust's board meeting. The Chief Executive regularly takes part in shadowing frontline staff, in different settings, to hear first hand feedback from staff and patients. The Trust has a feedback channel for staff, patients, visitors and members of the public to actively encourage ideas for quality improvement, with feedback on improvements and changes implemented shared widely.

For more information please see: www.northumbria.nhs.uk/patients-and-visitors/what-our-patients-say

citizens and communities. It will gather evidence of needs, views, aspirations and experiences in relation to health and care from citizens and communities to inform its work and to understand how effectively the system is delivering improvements to health and care.

Patient and Staff Feedback

2.48 The Government is committed to improving patients' experiences of NHS services and only by listening and responding to the views of patients, their families and carers will the NHS know that it is delivering high quality care in the eyes of patients and the public. This will mean making it easier for patients and carers to give feedback on their care and see reviews by other people, so that timely, easy-to-review feedback on NHS services becomes the norm.

2.49 A key aim of the NHS Commissioning Board, working with commissioners and providers, is to ensure that all NHS funded patients will have the opportunity to leave feedback in real time on any service by 2015, starting with the roll-out of the Friends and Family Test from April 2013. This is reflected through a new pledge in the NHS Constitution: "*The NHS commits to encourage and welcome feedback on your health and care experiences and use this to improve services.*"

2.50 Every patient and member of staff will, in the future, be able to say whether they would recommend their hospital to their friends or family through the Friends and

Family Test. The Friends and Family Test is a simple and comparable tool that can provide a mechanism to identify poor performance early. Alongside the results of patient surveys and feedback through complaints, it will help to improve services based on what patients and staff say. From April 2013, all providers of NHS Accident and Emergency and acute inpatient services will collect from patients, at discharge or up to 48 hours later, information on how likely they are to recommend the provider's services to their friends and family. From October 2013, the test will be rolled out to women who have used maternity services, and the NHS Commissioning Board will continue to work with providers to determine how the test can be rolled out further.

2.51 The NHS staff survey also provides important information about organisations' health. It asks whether staff would recommend their place of work to a family member or friend as a high-quality place to receive treatment and care, equivalent to the 'Friends and Family Test'. However, staff are only asked this question annually, and the NHS Commissioning Board will work to ensure that much more regular staff feedback on the 'Friends and Family Test' becomes the norm.

2.52 The feedback patients provide can also help doctors understand what they do well and where they can develop their professional skills. Revalidation now requires all doctors to take part in an independently administered feedback questionnaire from both colleagues and patients. With their appraiser, doctors will need to review and reflect on this feedback, as well as any additional complaints and compliments they have received from patients and relatives.

Complaints

2.53 The system must learn and improve from general feedback and from any complaints and concerns raised by patients, service users, families and carers. Complaints can be an early symptom of a problem within an organisation. We need to make the complaints procedure much easier. As Robert Francis highlights: "*Complaints, their source, their handling and their outcome provide an insight into the effectiveness of an organisation's ability to uphold both the fundamental standards and the culture of caring. They are a source of information that has hitherto been undervalued as a source of accountability and a basis for improvement. Learning from complaints must be effectively identified, disseminated and implemented, and it must be made known to the complainant and the public, subject to suitable anonymisation*".

2.54 The Department has established an independent review to consider the handling of concerns and complaints including relevant recommendations from Robert Francis' report. This Review will report in the summer. The Review is being led jointly by the Rt. Hon. Ann Clwyd, MP for Cynon Valley, and Professor Tricia Hart, Chief Executive of South Tees Hospitals NHS Foundation Trust. It will consider how patients, their carers and families are listened to, how what they say is acted upon, and will identify key components of good practice and how to improve its adoption. It will also look at how complainants can be supported more effectively during the complaints process through, for example, advice, mediation and advocacy; and include the handling of concerns raised by staff, including the support of whistleblowers. It will review the role of trusts' boards and senior managers in developing a culture that takes the concerns of individuals seriously. In carrying out its work, the Review will engage with patients and their carers and representatives, staff and managers to hear and understand their experience of the way

concerns and complaints are managed and acted on.

2.55 Where complaints cannot be resolved satisfactorily by a trust, they may be referred to the Parliamentary and Health Service Ombudsman. The Ombudsman is changing the way it works to start investigations sooner and complete them more quickly. The Ombudsman will publish summaries of all investigations to publicise both good and bad practice, so that the public can make better informed choices about their care. It will focus on identifying systemic issues arising from individual and clusters of complaints and publish more thematic case reports to highlight big or repeated complaints and to build confidence in the value of complaints. It will make it easier for people to complain to them and will work with regulators to drive better information sharing about complaints to gain earlier insight into concerns about quality.

Healthwatch

2.56 The creation of Healthwatch will be a key part of ensuring that the voice of the patient is listened to within the new system. Healthwatch England works at the national level providing leadership, support and advice to the local Healthwatch network. It will use evidence based experiences to highlight national issues and trends to influence national policy. Through the network and by receiving views directly, Healthwatch England will ensure that the voices of people who use health and social care services are heard by the Secretary of State for Health, the Care Quality Commission, the NHS Commissioning Board, Monitor and local authorities in England.

2.57 Healthwatch England will deliver a full offer of training and guidance over the next financial year to ensure and support the development of a vibrant and effective local Healthwatch network. This training will support both the leadership of local Healthwatch organisations, and volunteers and others who might get involved in the work of local Healthwatch.

2.58 Local Healthwatch organisations will be established in upper-tier and unitary local authority areas in England from 1 April 2013. A key role of local Healthwatch organisations will be to promote the local consumer voice to ensure that the views of patients, service users and the public are fed into improving local health and care services. The primary task of local Healthwatch organisations will be to gather evidence from the views and experiences of patients, service users, carers and the public about their local health and care services and to provide feedback based on that evidence.

2.59 Local Healthwatch will be able to 'enter and view' local health and care services to observe how effective those services are to help them gather a rounded picture of how services could or should be improved. Healthwatch England will be providing training to local Healthwatch organisations to support them to use effectively their ability to 'enter and view' health and care services in order to observe activities carried out there and provide recommendations or escalate concerns.

2.60 It is important that local Healthwatch organisations are diverse and inclusive of local people and communities. There is potential for all different types and levels of involvement of local people within local Healthwatch organisations.

2.61 Local Healthwatch organisations will build on the knowledge and experience of existing Local Involvement Networks (LINks), so ensuring continuity, and will reach out into parts of the community that do not currently have a voice. Robert Francis heard a lot of evidence about the experiences of Patient

and Public Involvement Forums (PPIFs) and LINks (predecessors to local Healthwatch) in Stafford. He has set out a number of recommendations based on the evidence he heard and we are considering how best to address these.

2.62 In care and support, we will take forward the *Caring for Our Future* White Paper[14] commitment to test out different approaches to make care homes more open to their local communities by encouraging different forms of lay visiting and also supporting visitors to know how to link to their local Healthwatch where they have concerns.

Sharing Information

2.63 As the Inquiry highlighted, the effective collection, analysis and dissemination of relevant information is essential for swift identification and prevention of substandard service, facilitating accountability, provision of accessible and relevant information to the public, and supporting patient choice of treatment.

2.64 The Chief Inspector needs to be able to consider data from a range of sources quickly to identify issues or trends that could indicate risks to quality. The Care Quality Commission needs to be alert to the signals from data and qualitative feedback, including from staff and patients, service users, their families and carers. Important early warning signs include intelligence from complaints and comments, and patient and staff surveys where changes to key scores can be an indicator that services are deteriorating. Differences between various parts of a hospital can also provide insights into which wards may be providing a lower quality of care for their patients.

Chapter Three – Taking Action Promptly

Summary

The Care Quality Commission, working with the National Institute for Health and Clinical Excellence (NICE), commissioners, patients and the public, will draw up a new set of simpler fundamental standards which make explicit the basic standards beneath which care should never fall. This will be in language that both the public and professionals can easily understand.

In the past, when poor care was detected, it has too often been put in a "too difficult" pile. Patients have been left with no one acting with urgency on their behalf to ensure a decent standard of care. This inaction will stop.

Freed up from the conflict of having to resolve poor hospital care through delegating Care Quality Commission enforcement powers to Monitor and the NHS Trust Development Authority, the Chief Inspector will identify poor care in public, and issue a call to action to the hospital itself and the regulators responsible for their oversight. A new time-limited three stage failure regime, encompassing not just finance, but for the first time quality, will ensure that where fundamental standards of care are being breached, firm action is taken until they are properly and promptly resolved.

In the first stage, the Chief Inspector will require the hospital board with its commissioners to improve within a fixed time period, but it will not be responsible for making it happen. In the second stage, if the hospital with its commissioners is unable to resolve its own problems, then Monitor or the NHS Trust Development Authority would step in to take action. In the final stage, where fundamental problems in the hospital mean that its problems cannot be resolved, the Chief Inspector will initiate a failure regime in which the Board is suspended or the hospital is put into administration.

Fundamental Standards

3.1 A key recommendation from Robert Francis' report related to setting fundamental standards. We accept this recommendation. These standards will help to set the context for delivering compassionate, safe care.

Already the system rightly has a focus on 'never events' – the errors that should never happen. These fundamental standards represent the basic requirements that should be the core of a quality services and they need to have a similar status to 'never' events.

3.2 As Robert Francis recommended, these standards must be developed with public involvement and consultation with staff. Department of Health will start work immediately with the Care Quality Commission, Monitor, NHS Trust Development Agency, the NHS Commissioning Board and NICE and then consult with the public to develop a small number of fundamental standards focusing on key areas of patient care. The Chief Inspector will use these standards, and the evidence from inspections, to make judgements about the quality of a hospital's services.

3.3 We will incorporate fundamental standards into the Care Quality Commission's registration system, which provides the independent assessment of quality. The standards are likely to include things like:

- People are getting the medicines they have been prescribed at the right time and the right dose, including appropriate pain relief;
- People are getting food and water, and help to eat and drink if they need it;
- People are being helped when they need it to go to the lavatory and not left in wet or soiled clothing or beds;
- People are being asked to consent to treatment and all staff communicate with patients effectively about their care and treatment; and
- The environment is clean and hygienic.

3.4 The fundamental standards, together with other important aspects on which inspections will focus, will sit within some of the five areas below:

- Caring: such as dignity, compassion, or pain relief
- Safe: such as avoiding pressure ulcers, MRSA, wrong site surgery, medication errors
- Responsive: such as waiting times, A&E waits and ease of access for appointments
- Effective: such as mortality rates, complications and readmissions; recovery rates; management of long term conditions
- Well led: such as visible leadership, organisational culture, helpful staff, openness and transparency.

3.5 As Robert Francis envisaged, the fundamental standards will be complemented by enhanced and developmental standards. To implement this approach, NICE will extend the scope of its quality standard programme to provide guidance on known good practice in providing excellent care.

Time Limited Failure Regime for Quality as Well as Finance

3.6 A critical finding from Robert Francis' report was the significant failures of accountability and transparency in the role of system managers and regulators. He found that their focus was directed at financial and organisational issues rather than the protection of patients and ensuring that patient safety and quality standards were being observed. He attributed this to poor communication, misaligned methods of assessment, and an over-reliance on assurances given by other organisations. A key recommendation was that there should be a *'single regulator dealing with both corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts'.*

3.7 Since 2009, Monitor and the Care Quality Commission have worked to develop

a better working relationship and improve the coordination of their regulatory activities. This was strengthened by the Health and Social Care Act 2012, which makes Monitor and the Care Quality Commission subject to stronger duties of cooperation and requires them to operate a joint application process for the Care Quality Commission registration and a Monitor licence. However, the public still lacks clarity over who in the regulatory system will take action when there are serious failures of care in hospitals.

3.8 The Government agrees that regulators and commissioners should ensure they have a shared picture of provider performance, and that there should be greater transparency in identifying those that are failing to meet fundamental standards. In addition, the Government agrees that better communication and greater co-ordination is required between the Care Quality Commission and Monitor.

3.9 We believe there continues to be a strong case for maintaining the Care Quality Commission and Monitor as separate organisations fulfilling distinctly different functions. Assessing quality and highlighting failures of care should not be conflated with the responsibility for overseeing the turnaround of failing NHS providers. So, rather than merging the responsibilities of the regulators, we will deliver Robert Francis' vision through a single failure regime that will place the same emphasis on addressing failures in quality of care as there is on financial failure.

3.10 In delivering this regime, the Care Quality Commission, Monitor and the NHS Trust Development Authority will work closely with each other and with commissioners, who will have a role in driving improvement and service change. We are mindful that this approach should not increase the overall level of regulatory burden, and in developing the regime we will consider the recommendations from the NHS Confederation's Review of Bureaucratic Burdens outlined earlier in this document.

3.11 The single failure regime will deliver a clear and co-coordinated regulatory approach to identifying and tackling failures of quality. There will be three elements to the proposed failure regime:

- It is essential that there is a common understanding of provider performance amongst regulatory bodies and commissioners – a '*single version of the truth*'. There will be a single rating of providers led by the Chief Inspector of Hospitals at the Care Quality Commission which draws on information and assessments from Monitor and the NHS Trust Development Authority on finance. The Chief Inspector of Hospitals will champion excellent care. The regulatory bodies and the NHS Commissioning Board will agree a single national definition of quality, consistent with the Mandate and the NHS Outcomes Framework. This agreed quality framework will include consistent use of data to support assessment. The application of the national method will take account of the need to reflect, and not crowd out, local commissioner priorities. The Care Quality Commission will have an increasingly prominent role in Quality Surveillance Groups in assessing the quality of providers.
- Where quality is poor, the Chief Inspector will require the board of the provider with its commissioners to improve, within a fixed period. But the Care Quality Commission will not then be responsible for making it happen. The principle that responsibility for dealing with the problem lies with the provider, rather than external bodies, will not change. If the

provider is unable to resolve the situation in partnership with commissioners, and problems persist, Monitor or the NHS Trust Development Authority would step in, potentially following a request from the Chief Inspector. Monitor and the NTDA retain their current ability to intervene at their discretion if urgent regulatory action is required. The same level of intervention will be possible in response to quality failings as for finance and governance failings.

- In some cases, however, it may become clear that more fundamental issues prevent an NHS foundation trust or NHS trust from making the necessary improvements in quality of care. For these rare cases of clinically unsustainable providers, we will ensure there is a suitable mechanism to ensure that the local population can access a comprehensive range of safe, sustainable health services.

3.12 In care and support, we similarly need a single and consistent approach to failure that can give people the confidence that quality failings will not be tolerated. The Government has recently consulted on a new approach to overseeing financial performance and managing financial failure in the care and support market. The Government will set out its detailed plans shortly. The new Chief Inspector of Social Care will have an important role in ensuring that judgements about the quality of care is a central consideration, in any new future failure system for providers of social care.

Foundation Trust Status

3.13 Robert Francis' report makes clear that the first priority for all provider organisations, and for the bodies that oversee them, should be to secure high quality services for patients. We have made quality improvement a statutory duty for commissioners. In the case of Mid Staffordshire NHS Foundation Trust, the pursuit of foundation trust status became a distraction from this goal. Acquiring the badge of foundation trust status became an end in its own right and patient care suffered as a result. Moreover, the foundation trust assessment process at that time paid too little attention to the quality of care, meaning Mid Staffordshire NHS Foundation Trust's tragic loss of focus was not challenged. We are determined to ensure these mistakes cannot happen again.

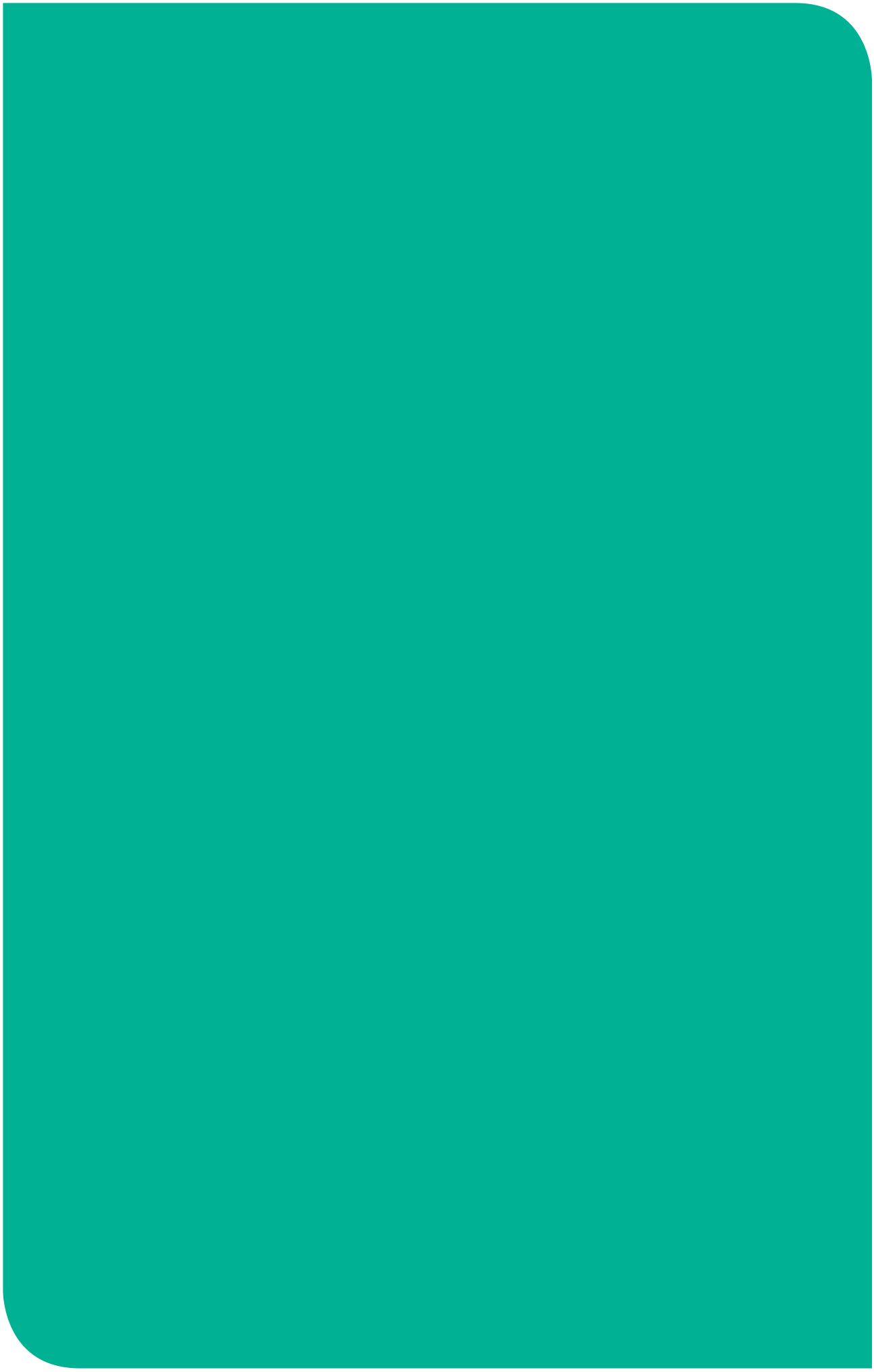
3.14 Robert Francis argued for a single regulator, the Care Quality Commission, taking on responsibility for foundation trust authorisation. We agree that the delivery of good quality and safe care should be a central requirement on any trust wishing to attain foundation trust status, but we do not think that the foundation trust authorisation role should rest with the Care Quality Commission. We think it should remain with Monitor. Through changes to the processes undertaken by Monitor, much has already been done to ensure that the foundation trust assessment process now has quality of care at its heart. This includes a clearer role for the Care Quality Commission. Monitor will not authorise a trust as a foundation trust unless the Care Quality Commission indicates that they are content that the trust is compliant with basic standards of care. Furthermore, with the creation of the new NHS Trust Development Authority, there is an opportunity to strengthen further the focus on quality in the way that NHS trusts are overseen and prepared for foundation trust status. The NHS Trust Development Authority will have a clear focus on improving the quality of care in NHS trusts and ensuring that only high quality providers are considered for foundation trust status, in line

with the recommendations in Robert Francis' report.

3.15 The NHS Trust Development Authority will set out initial plans to address the recommendations that it is leading on, including some of those relating to the foundation trust application process and the approach to oversight and performance management of providers, through its Accountability Framework for NHS Trust Boards, which will operate from April 2013.

3.16 The Government's ambition is clear. We want NHS trusts to improve the quality and sustainability of services as quickly as possible. It is vital that the focus on improving quality cannot be compromised by a focus on the pursuit of foundation trust status for its own sake. So where time is needed to make the necessary improvement, it is important that the process is not rushed and that risks to patient care are not created.

3.17 The 2014 deadline for reaching foundation trust status has done much to galvanise the NHS trust sector and drive improvement. However, in light of Robert Francis' report, we have allowed the NHS Trust Development Authority to agree trajectories for NHS trusts to reach foundation trust status that go beyond 2014 on a case by case basis. In so doing, we will ensure that the primary focus of the NHS Trust Development Authority and of NHS trusts themselves is on improving the quality and sustainability of services for patients.



Chapter Four – Ensuring Robust Accountability

Summary

Where the Chief Inspector identifies criminally negligent practice in hospitals, he or she will refer the matter to the Health and Safety Executive to consider whether criminal prosecution of individuals or boards is necessary.

The General Medical Council, Nursing and Midwifery Council and the other professional regulators are hampered by an outdated legislative framework that is too slow and reactive in tackling poor care by individual professionals. As part of the implementation of the Law Commission's review, we will radically overhaul 150 years of complex legislation into a single Act that ensures much faster and more proactive action on individual professional failings.

To deal with the small numbers of managers who let their patients and the NHS down, and prevent them from moving to new jobs in the NHS, we will introduce a national barring list for unfit managers, based on the barring scheme for teachers.

The Chief Inspector of Hospitals will assure, as part of inspections, that all hospitals are meeting their legal obligations to ensure that unsuitable healthcare assistants are barred from future patient care by properly and consistently applying the Home Office's barring regime.

It is primarily for providers and commissioners to identify and resolve problems, working together for the patients that they serve. But at a national level, these proposals will resolve the confusion of roles and responsibilities in the system, so it is clear where the buck stops on poor care. The Chief Inspector will identify failing standards. Monitor and the NHS Trust Development Authority will resolve them. The Department of Health will act as the patients' champion in the system to ensure that everyone plays their part on patients' behalf.

Introduction

4.1 Clear accountability for boards and organisations is essential so that they understand their responsibilities to patients. Whilst the Government will assess the desirability of criminal sanctions for individual members of staff below board level in the light of the Berwick Review and potential enhancements to professional regulation, it agrees that there needs to be stronger accountability for boards.

Health and Safety Executive to use Criminal Sanctions

4.2 If the Chief Inspector finds a potential breach of health and safety requirements, the Care Quality Commission would refer the matter immediately to the Health and Safety Executive, which in serious cases could use its existing powers to prosecute. The Department of Health will work with the Department for Work and Pensions and the Health and Safety Executive to ensure that the Health and Safety Executive has the necessary capacity to act.

Faster and Proactive Professional Regulation

4.3 Robert Francis made a number of recommendations directed at the professional regulators for doctors and nurses: the General Medical Council and the Nursing and Midwifery Council, in particular to ensure they act quickly on concerns, share information with other regulators more proactively and put greater emphasis on protecting patients and the public. These principles affect all professional regulators.

4.4 The General Medical Council and the Nursing and Midwifery Council, together with other professional regulators, will consider these recommendations further before making a fuller response. However, both regulators are already taking further action to act more quickly to address concerns raised with them about the fitness to practice of individual clinicians. They are also engaging more actively with other parts of the system, in sharing and using information, for example through the National Quality Board's Quality Surveillance Groups.

4.5 For example, the Nursing and Midwifery Council has refocused its core regulatory purpose and has built in public protection at the centre of what they do. Since 2009 the Nursing and Midwifery Council has:

- published new standards for pre-registration nursing education in 2010 which place significant emphasis on care and compassion of patients;
- introduced a helpline for directors of nursing as the first point of contact to discuss fitness to practise issues;
- run employer's roadshows and events to raise profile amongst employers;
- developed a new case management tool to encourage early resolution of cases and a new voluntary removal process;
- developed greater transparency by ensuring details of nurses and midwives who have been struck off or suspended in the last five years are visible through searching our online register; and
- begun work on an appropriate model of revalidation, to ensure continuing fitness to practise, of nurses could be introduced.

4.6 More recently the Nursing and Midwifery Council has embarked on a programme of work to respond to Robert Francis' specific recommendations, considering how they can raise their public profile, ensure resources are effectively targeted, improve joint-working arrangements with other professional and systems regulators and review their education and professional standards.

4.7 The General Medical Council is engaged in programmes of work to:

- embed revalidation for doctors;
- change its relationship with doctors and patients;
- develop a stronger local presence;

- support doctors at all stages of their careers;
- provide leadership and guidance to the profession;
- work with others and share data;
- reform fitness to practice procedures, for example with the introduction of the Medical Practitioners Tribunal Service in 2012; and
- in cooperation with Government, develop further language controls in relation to foreign doctors.

4.8 Robert Francis' report marks a period of increased scrutiny for the professional regulators. The former Council for Healthcare Regulatory Excellence (now the Professional Standards Authority) also raised concerns in relation to the Nursing and Midwifery Council in its report, *Strategic Review of the Nursing and Midwifery Council*, July 2012.[15] The legal framework relating to the regulation of healthcare professionals, and in England social workers, is currently under review by the Law Commission. The Law Commission has issued a consultation paper making provisional proposals that seek to simplify and modernise the law and establish a streamlined, transparent and responsive system of regulation. Amongst other things, the review will consider legislation on the investigation and adjudication of fitness to practise cases.

The Teaching Agency – Example of a Barring Scheme

The agency supports the quality and status of the teaching profession by ensuring that in cases of serious professional misconduct, teachers can be barred from teaching. The regulatory function includes all teachers and instructors in all maintained schools, non-maintained special schools, academies and free schools, sixth-form colleges, independent schools and relevant youth accommodation and children's homes in England.

To this end, the agency:

- screens and sifts all cases of serious professional teacher misconduct referred to the Secretary of State to determine whether the case should be formally investigated;
- investigates cases and, where appropriate, passes to a Professional Conduct Panel hearing, which will recommend to the Secretary of State whether a prohibition order is appropriate;
- puts interim prohibition orders in place where there are extremely serious allegations that can be substantiated;
- organises and administers Professional Conduct Panels;
- administers and manages the list of prohibited teachers;
- compiles and evaluates evidence, seeking expert advice (legal, medical etc) as appropriate;
- liaises and shares information as appropriate with devolved administration GTCs, the police, other regulators and the Disclosure and Barring Service (DBS); and
- organises and considers cases of whether a prohibition order should be set aside.

Directors and Senior Leaders

4.9 Good leadership is critical to ensuring that patients receive excellent care from well-supported and well-motivated staff, working in a culture focussed on patients' needs. Chapter Five sets out how we will help ensure the NHS can recruit and develop its leaders – from within the NHS, from the clinical professions and from outside the health and care system. The Inquiry also identified the need to ensure that, for the small number of leaders who let down their patients, their staff and the NHS, there is a mechanism in place which prevents unsuitable board level executives and non-executives from moving to new senior positions elsewhere in the system.

4.10 The Government agrees and will establish a barring mechanism to ensure that individuals whose conduct or competence makes them unsuitable for these vital roles are prevented from securing them. However, such a scheme needs to be developed very carefully so that it enhances professional esteem for the vast majority of senior leaders and does not discourage capable and experienced individuals from serving in both executive and non-executive roles. Whilst patients and the public will want to have confidence that the mechanism is robust, equally senior leaders will need to be assured that it is fair, independent and has effective safeguards. The Department of Health will work with staff representatives, patients and the public to draw up consultation proposals to meet these aims and seek to legislate when time is available for Parliament to consider the Law Commission's proposals on professional regulation. We will consult on whether the scheme should extend beyond board level to other managers.

4.11 While for redundancy payments, normal statutory and contractual arrangements will continue to apply, the Government is concerned to ensure that severance payments for senior managers should be proportionate. We are considering the options and will make an announcement shortly on these matters.

4.12 The Department will also discuss with the profession whether an assured voluntary register would help give effect to the Professional Standards Authority's recently published standards and code of conduct for senior NHS leaders.

4.13 In the meantime, Monitor, the Care Quality Commission and the NHS Trust Development Authority will be developing proposals on a fit and proper person test for board level directors, covering basic issues such as bankruptcy and criminal convictions.

Barring System for Healthcare Assistants Enforced by Chief Inspectors

4.14 The Chief Inspectors will assure, as part of inspections, that all hospitals and care homes are meeting their legal obligations to ensure that unsuitable health and social care assistants are barred from future care by properly and consistently applying the Home Office's barring regime.

Clear Responsibilities for Tackling Failure

4.15 At a national level, these proposals will resolve the confusion of roles and responsibilities in the system, so it is clear where the buck stops on poor care when commissioners and providers are unable to do so quickly. The Chief Inspector will identify failing standards. Monitor and the NHS Trust Development Authority will resolve them. The NHS Commissioning Board will support

Disclosure and Barring Service

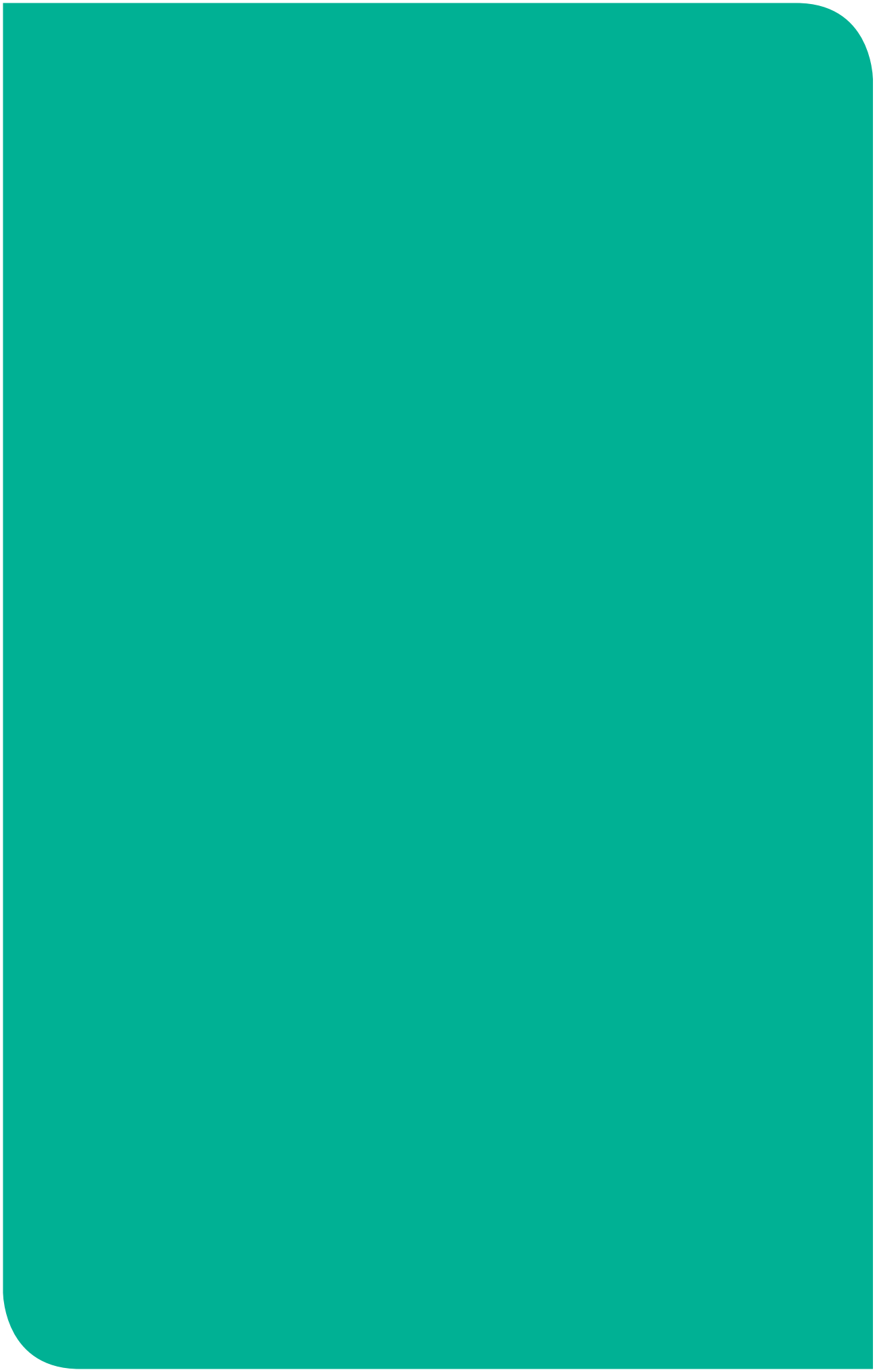
The Disclosure and Barring Service (DBS) took over the functions of the Criminal Records Bureau and the Independent Safeguarding Authority in December 2012, and issues criminal records certificates and makes independent decisions about who should be placed on the barred lists. http://www.homeoffice.gov.uk/agencies-public-bodies/dbs/

There is a legal duty for providers, including NHS organisations, care homes and domiciliary care agencies, to refer people to the DBS. 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.

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 DBS for an enhanced DBS 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.

Clinical Commissioning Groups in improving commissioning. The Department of Health will ensure that everyone plays their part on patients' behalf.



Chapter Five – Ensuring Staff are Trained and Motivated

Summary

Starting with pilots, every student who seeks NHS funding for nursing degrees should first serve up to a year as a healthcare assistant, to promote frontline caring experience and values, as well as academic strength.

Building on the historic introduction of medical revalidation, which offers proactive assurance of individual doctors, when the Nursing and Midwifery Council turns around its current poor performance, we will introduce a national scheme for already qualified nurses to ensure all nurses are up to date and fit to practise**.**

Camilla Cavendish is reviewing how best to ensure healthcare and care assistants can provide safe and compassionate care to patients. We are today publishing standards of conduct and training for all care assistants. The Chief Inspectors will ensure that all employers are meeting their requirements to ensure that all healthcare and care assistants are properly trained and inducted before they care for people.

The NHS Leadership Academy, in addition to its existing work to ensure that top leaders have the right skills and the right values, will initiate a major programme to ensure new talent from the clinical professions and from outside the NHS is drawn into top leadership positions. Working with world class universities, we will develop a fast track programme for Chief Executives to attract the brightest and best to top NHS jobs.

At the centre of the system, the Department of Health, with its new role as champion of the patient, will need to reconnect radically with the patients it serves. By 2016 every Department of Health civil servant will have real and extensive frontline experience of caring for patients and will bring this essential experience to their policy advisory role and to the Department's stewardship of the health and care system.

Treating staff well

5.1 Organisations need to have a clear aspiration to create the right conditions that enable their staff to deliver high quality, effective and compassionate care. Across health and social care, organisations should be aspiring to excellence in recruitment, induction, training and appraisals for all staff and tackle any inconsistencies in good practice. There is already good evidence to show organisations that treat their staff well deliver better outcomes for patients[16, 17].

Staffing Levels

5.2 Staff need capability and capacity to do their job properly – clarity about roles and responsibilities, team structures, team working and cooperation. Key to enabling staff to deliver high quality care is ensuring we have the right staff, with the right values, skills and training available in the right numbers to support the delivery of excellent care. This depends on the needs of patients on each ward at any time.

5.3 Right staffing in terms of numbers and skills is vital for good care, but minimum staffing numbers and ratios risk leading to a lack of flexibility or organisations seeking to achieve staffing levels only at the minimum level. However adequate staffing levels are essential to provide proper care and the new Chief Inspector will have a clear remit to inspect staffing levels and report if they are inappropriate.

5.4 Local NHS organisations are best placed to take responsibility for the skill mix of their workforce because they are best placed to assess the health needs of their local health community and must have the freedom to deploy staff in ways appropriate for local conditions. We support Robert Francis' call for evidence-based guidance and tools to inform decisions made by local professional leaders on appropriate staffing levels for high quality and we will work with NICE, the Care Quality Commission and the NHS Commissioning Board on this recommendation.

5.5 The Care Quality Commission will require that evidence-based tools are used to determine staffing numbers. *Compassion in Practice*[2] recommends that the trust board receives, publishes and endorses information on staffing at least twice a year.

5.6 The majority of hospitals have introduced hour by hour nursing rounds on

Compassion in Practice – "The 6Cs"
Care, Compassion, Competence, Communication, Courage and Commitment.

Compassion in Practice (the nursing, midwifery and care staff vision and strategy for England) was launched in December 2012 at the Chief Nursing Officer's Conference. Compassion in Practice was developed with nurses, midwives and care staff up and down the country. There was an eight week engagement period prior to the launch of Compassion in Practice when spoke to over 9,000 people including nurses, midwives, care staff, patients, people we care for and stakeholders. We also used social media to engage people in the 6Cs and had over three million twitter impressions.

As well as the clear focus on the 6Cs, Compassion in Practice sets out six areas of action to concentrate our effort and create impact for our patients and the people we support. These six areas of action will be delivered together as one programme to achieve the values and behaviours of the 6Cs.

Over the last three months nurses, midwives and care staff, as well as stakeholders at national and organisational level, have developed implementation plans to support the delivery of the values and behaviours of the 6Cs.

To find out more and to see the implementation plans visit: www.commissioningboard.nhs.uk/nursingvision

The Nursing and Care Quality Forum

In January 2012, the Prime Minister created the Nursing and Care Quality Forum, bringing together patients, voluntary organisations, front line staff and leaders in the field, asking them to take on a national leadership role in promoting excellent care and ensuring good practice is adopted across the NHS and social care. The Forum has been active in highlighting the issues which need to be addressed in improving care on the national level. They have promoted the use of technology to reduce bureaucracy, emphasised the need for better leadership and recruiting health and care staff based on their values.

their wards. The forthcoming *Compassion in Practice* action plans will urge the remaining hospitals to do so within a year.

Making Time to Care

5.7 A key to improving working lives for staff is to reduce the volume of paperwork they are required to fill in so that they can focus the vast majority of their time on their patients. Over the next ten years, technology will transform the experiences of staff enabling them to spend more time caring for people.

5.8 In addition to the measures already described in Chapter 1 to tackle bureaucracy, the NHS Commissioning Board has committed to supporting commissioners to provide staff with digital technology that helps them manage health and care work and to support a move to paperless referrals in the NHS by March 2015. In October 2012, the Government announced the establishment of a £100m technology fund to help equip nurses and midwives with latest technologies designed to help them to provide safer, more effective and more efficient care to patients and service users. The types of technologies this fund will help the NHS to embrace include digital pens for use in many different settings and mobile or handheld devices for hospital based nurses which will allow them to input patient observations at the bedside or point of care and for community nurses to input data when they are away from their base. The Fund will be available during 2013/14 and 2014/15. Following further consultation with internal and external stakeholders, further details on the roll out of the Fund will be released at the start of the new Financial Year.

Rewarding High Quality Care

5.9 We know that high performing staff can improve the outcome for patients. It is therefore right that we recognise this in the way we reward staff. Pay progression should be more closely linked to performance and delivering high quality patient care. We will strongly encourage employers to use the full flexibilities in existing pay contracts so that pay progression is linked to quality of care, not time served.

5.10 NHS Employers will support this by working with the service on new model performance frameworks, which will place greater emphasis on the quality of care, including the important NHS values of compassion, dignity and respect.

5.11 We will also ensure that medical pay rewards current excellence, rather than historical performance.

South Warwickshire – Restorative supervision

Restorative supervision was designed to address the emotional demands of nursing and health visiting staff, supporting them to build resilience and reduce their own stress and burnout levels. It is a sustainable, low-cost model: staff meet with a trained supervisor for a series of six sessions. Research has found that restorative supervision increased compassion satisfaction (the pleasure staff derive from doing their job) as well as reducing burnout and stress by over 40%.

Sarah, a 45 year-old midwife had worked on an acute ward for 19 years. When she came for her first session of restorative supervision her physical presentation suggested that she was washed out. She looked exhausted and spent a lot of the time within the session sighing heavily and explaining why everything was so difficult and nothing could be done to change things for her. Following the process, she commented: *"Today, I felt great – I was prepared to tackle anything that came my way. I remember going back to the office as if it was my first day as a midwife feeling full of energy – thank-you."*

To find out more, please see: www.restorativesupervision.org.uk

Listening to Staff

5.12 Ensuring effective staff engagement is also crucial to promoting better outcomes for patients and their care. There is a need for mutual value and respect between different staff groups and all organisations across health and care need to focus on listening to staff and enabling them to influence decisions that affect the services and care they deliver. Organisations should be actively using information such as the NHS Staff Survey results to review and improve staff experience so that staff can provide better care.

Recruitment and Training – Health Education England

5.13 Robert Francis recommended that the NHS should recruit and train staff to demonstrate the right values and behaviours – and to challenge colleagues who do not – so that we can ensure the quality of care is as important as the quality of treatment. Health Education England will introduce values-based recruitment for all students entering NHS-funded clinical education programmes. This will include testing for values, face-to-face interviews and scenario testing to assess candidate's attitudes towards caring, compassion and other necessary professional values. Health Education England will also work with NHS Employers on aptitude tests which can be used more widely. In addition, the Department will discuss with Health Education England and the nursing profession options to make it easier for healthcare assistants to train and qualify as nurses, with their vocational experience counting towards their degree.

5.14 Starting with pilots, every student who seeks NHS funding for nursing degrees should first serve up to a year as a healthcare assistant, to promote frontline caring experience and values, as well as academic strength. They will also provide students with helpful experience for managing healthcare assistants when they qualify and enter practice. The scheme will need to be tested and implemented carefully to ensure that it

is neutral in terms of costs. Health Education England will work with the Nursing and Midwifery Council, professional leaders and trade unions in developing the pilots. We will explore whether there is merit in extending this principle to other NHS trainees.

Revalidation for Nurses

5.15 The Nursing and Midwifery Councils's current focus must be to ensure that the recent improvements in its performance are sustained and that public and professional confidence is restored. When that is secured, the Chief Nursing Officer and the Department of Health's Director of Nursing will work with the Nursing and Midwifery Council in developing an effective and affordable approach to revalidation appropriate and proportionate to nursing and midwifery professions. Should legislative change be required to strengthen the powers of the Nursing and Midwifery Council, this would be taken forward in line with the Government's legislative programme.

5.16 In the interim, appraisals will be strengthened, made more consistent and explicitly include values and behaviours. The Department will work with health and care services to ensure that the organisation's director or lead for nursing and care lead this process and act upon the training and support needs identified.

5.17 The Department of Health agrees in principle to the recommendations but needs to do more work with the Nursing and Midwifery Council and other stakeholders to consider how the proposed model to ensure continuing fitness to practise for nurses and midwives can be developed to work. The concept of the Responsible Officer for nursing raises issues about the role of directors of nursing in trusts or any organisation's lead for nursing and care, which the Nursing and Midwifery Council will examine in the light of revaluation proposals.

5.18 The Royal College of Nursing has an important role in developing and promoting the art, science and practice of nursing. The Government believes a clearer distinction between its professional and trade union roles, both important, would enhance the authority of its work.

Nursing Supervisory Ward Managers

5.19 There is a good body of evidence to demonstrate that supervisory roles for Ward Managers (including Sister, Charge Nurse andTeam Leader) are important to delivering oversight to all aspects of care on a ward and in a community, from cleanliness to allocation of staff[18, 19]. Moreover, nurse leadership at ward level provided by a Ward Manager is important to the delivery of safe high-quality care to patients.

5.20 A 'supervisory' role is about having the time to lead, support staff in their clinical role and ensure patients are having a good experience of care. We recognise that many ward managers currently have the same caseload as other nurses on the ward, which does not always allow them time to perform the full scope of the supervisory role.

5.21 Having sufficient nurses trained and with the capacity to respond to ensure the delivery of safe, patient focused care is currently a core standard requirement of the Care Quality Commission. *Compassion in Practice* commits to ensuring we have the right staff, with the right skills in the right place. This includes supporting leaders to be supervisory, giving them time to lead action plans by December 2013.

Supervisory Nurse Ward Managers

Wrightington, Wigan and Leigh NHS Foundation Trust found that it is imperative that the Ward Manager role becomes supervisory to clinical practice. In a review of Nursing Establishment (2012), the Trust Board approved the requested uplift in establishment, which equates to the current level of temporary spend, and forecasted outturn of £2.1 million. Within the report, the Trust Board recognised the need to strengthen the role of the Ward/Departmental Manager in driving quality and safety; provide active and visible clinical leadership; provide reassurance for service users and staff in all care settings reflecting the proposed changes announced by the Prime Minister on 6 January 2012.

County Durham and Darlington NHS Foundation Trust reported ward sisters spending 80% of their time on supervising wards and 20% delivering care. Recruiting 40 band 5 nurses enabled ward sisters to devote their time to leadership and management roles. The trust approved £800,000 per year to support the establishment and ward manager education and training.

Central Manchester University Hospitals NHS Foundation Trust report ward managers spending half their time in a supervisory role and the remainder as part of the direct care-giving team, which means that they can devote their leadership time to budget setting, managing sickness, recruiting and retaining staff, meet patient expectations, reduce complaints and deliver additional duties that are pivotal to good care .

Salford Royal NHS Foundation Trust highlighted a number of initiatives that demonstrated an excellent track record with nursing care, including the Nursing Assessment and Accreditation System (NAAS) which enables the ward matron to operate at a higher level of autonomy. Ward matrons have led quality improvements through the SCAPE (safe, clean and personal every time) status, approved by Board of Directors, to deliver 92% patients harm free as measured by the safety thermometer, 78% reduction in C Difficile, 71% reduction in cardiac arrests, 56% reduction in pressure ulcers, and 17% reduction in falls.

Health and Care Support Workers

5.22 The idea of compulsory, statutory regulation can seem an attractive means of ensuring patient safety, yet Rober Francis' report demonstrates that regulation does not prevent poor care. Regulation is no substitute for a culture of compassion, safe delegation and effective supervision. Putting people on a centrally held register does not guarantee public protection. Rather it is about employers, commissioners and providers ensuring they have the right processes in place to ensure they have the right staff with the right skills to deliver the right care in the right way to patients.

5.23 Arrangements for induction, training and performance managing healthcare assistants are uneven between trusts and sometimes underdeveloped. Because each trust implements its own way of induction it is very difficult to know just how much training a healthcare assistant has had before dealing with patients. This is not acceptable and

Proper induction and training for staff to support quality and safety

As part of its inspection regime, the Care Quality Commission expects providers to comply with standards of quality and safety.

People should be cared for by staff who are properly trained and supervised, have the chance to develop and improve their skills, and are properly qualified and able to do their job.

CQC requires providers to be managing quality and safety by employing the right people, staff who are:

- competent and have the required qualifications, knowledge, skills and experience to carry out the roles which they have been assigned;
- appropriately trained to provide safe and quality care, treatment and support;
- appropriately supervised and supported.

Building on this Skills for Health and Skills for Care have published a code of conduct and national minimum training standards for healthcare support workers and adult social care workers in England. Those standards of training provide the foundation for safe and effective practice, and should form the basis of the Care Quality Commission's assessment of training standards for all staff.

www.skillsforhealth.org.uk/codeofconductandtrainingstandards

this is one of the reasons we asked Camilla Cavendish to carry out her review (see later). The Chief Inspector of Hospitals will ensure that all hospitals are acting to ensure that all healthcare assistants are properly trained and inducted before they care for people. The new Chief Inspector for Social Care will also ensure that all unregulated social care support staff have the induction and training they need to meet their employers' registration requirements.

5.24 We have already announced further measures to support health and care support workers, such as the £13 million innovation fund for the training and education of unregulated health professionals, and the development by Skills for Health and Skills for Care in developing minimum training standards and a code of conduct for healthcare support workers and adult social care workers in England.

5.25 Further work is underway on recruiting, training, support and progression for health and care support workers, including:

- An independent review undertaken by Camilla Cavendish to look at how the training and support of healthcare and care assistants can be strengthened so that they provide safe and compassionate care to all people using NHS and social care services;
- The Government's mandate to Health Education England which will set an objective for the new organisation to work with employers to improve the capability and training standards of the care assistant workforce. Health Education England will develop a strategy

and implementation plan to achieve this, building on the Cavendish review and the work by Skills for Health and Skills for Care on minimum training standards and engaging with other relevant partners;

- Care Quality Commission inspections of induction training for health and care support workers will enable it to focus its energies where it is most effective and most needed.

5.26 As these work programmes develop, their outputs will further inform the Department of Health's thinking and action on how the public protection is ensured most effectively through a workforce that is appropriately recruited and developed to provide care that is dignified, respectful and compassionate.

Caring for Older People

5.27 Caring for older people is core to the job of many nurses working in wards throughout hospitals and across community settings. Providing high quality care and support to older people means removing the barriers to integration of care services, both national and local, to provide responsive, appropriate, person-centred care. The Care and Support White Paper contains a commitment to '*taking integration further*' that will start to tackle barriers at a national level. The Department of Health will work with the NHS Commissioning Board, Health Education England, Monitor, Public Health England, Skills for Care and Skills for Health, the Local Government Association and the Association of Directors of Adult Social Services to establish the best ways to promote and enable integration of local services and will jointly publish in May a common purpose framework. We have also set out clear obligations in the Health and Social Care Act 2012 and are reinforcing these messages in the NHS Constitution, the Mandate to the NHS Commissioning Board, and the Outcomes Frameworks for health, social care and public health.

5.28 Robert Francis recommended the creation of a separate registered older person's nurse role. However, many older people in hospitals are under the care of specialist teams (for example orthopaedics or cancer services) and require nurses to have those specialist skills. Additionally care of older people with many conditions and frailty can take place in their own home and care homes as well as in hospitals. Therefore, instead of setting up this specific role we will go further. We will strengthen the focus on the complex physical and emotional needs of frail older people throughout nursing and other healthcare training to ensure that older people needing nursing care will benefit from a nursing workforce that is trained to deal with their needs.

5.29 We will work with Health Education England, Higher Education Institutions and the Nursing and Midwifery Council to review the content of Registered Nurse Adult branch pre registration education to ensure all new nurses have skills to work with the large numbers of older people in all parts of hospital and beyond. We will also work with Health Education England to develop specific post-graduate training for nurses caring for older people with complex needs and frailty in care settings.

5.30 We are also committed to improving education and training on dementia. A wide programme of work is underway including work with e-learning for healthcare to develop a series of ten e-learning sessions on dementia for health and social care staff, the provision of £2.4m Dementia Workforce Development Fund to support the completion of accredited qualifications on dementia by social care staff, a survey of the dementia content of medical school curricula and work with Skills for Care and Skills for Health

"Barbara's Story" – Increasing Awareness of Dementia

A quarter of patients in UK hospitals have a dementia many of whom will be older people, and this number is growing. In September 2012 , Eileen Sills, Chief Nurse at Guy's and St Thomas' NHS Foundation Trust (GSTT), began a campaign to raise awareness of dementia for staff working in hospitals and in the community.

All 12,500 staff will be attending an innovative training session, where staff watch Barbara's story – a powerful film that was created by GSTT about a woman with dementia, and her experiences during a hospital visit. The video focusses on the care of older people with dementia, although the principles apply to all patients. Initial training sessions have prompted positive feedback from staff. One staff member commented that, "*It is a powerful reminder of just how important everyone's contribution is when it comes to creating a safe and positive environment across the organisation.*"

This initiative is run in partnership with The Burdett Trust. For more information, please see:

www.guysandstthomas.nhs.uk/education-and-training/staff-training/Barbaras-story.aspx

to develop Common Core Principles for Supporting People with Dementia.

Attracting Professional and External Leaders to Senior Management Roles

5.31 There is a wealth of evidence and understanding about what is required to deliver safe, compassionate, high quality care. The challenge of translating understanding into reality is primarily one of leadership.

5.32 Cultural change is not something that can be undertaken lightly or half-heartedly. It is one of the hardest things that leaders can do, and needs their wholehearted commitment. It is vital that attempts to change culture do not simply focus on surface-level observable behaviours. Meaningful change is only possible if deeply ingrained beliefs and assumptions are brought into the light and discussed. This is necessarily an uncomfortable process, and requires courageous, authentic leadership.

5.33 To ensure the system has leaders with the right values, behaviours and competencies, we are developing leaders and leadership at every level to influence the culture and values of the NHS from 'ward to board'. The NHS Leadership Academy which has already been established can fulfil Robert Francis' recommendation for a leadership college, working with a range of academic and private sector partners. The NHS Leadership Academy's development programmes will see a range of NHS staff, including doctors, allied health professionals, nurses, midwives, pharmacists and healthcare scientists learn to lead their teams, services and organisations to achieve better, more compassionate patient care. Up to £40 million will be invested in nurse leadership at all stages of the nursing career. We will ensure that the investment in development of general managers includes the importance of front-line work with patients.

5.34 We want to build the capacity and diversity of our top leaders and we will ensure that the work of the NHS Leadership

Academy gives very strong attention to developing senior clinical leaders, with the right masters-level support to bring them up to speed with the managerial and business requirements of leadership. We will invest in MBA style programmes to ensure that clinicians with a talent for leadership are supported in becoming the clinical Chief Executives of tomorrow.

5.35 As well as promoting better senior leadership through the NHS Leadership Academy, we know that highly experienced senior leaders from other sectors want to join the NHS and that the NHS would benefit from their talents. It is crucial to offer them the support they need, allowing them to understand quickly the complexities of delivering high quality compassionate healthcare as they blend their expert knowledge, skill and experience from other sectors with those in the NHS. We will develop a programme that will enable these leaders to enter the NHS more easily through a fast-track programme which will combine the very best of healthcare know-how with knowledge and support from prestigious academic institutions. Key components will include working with patients and staff from across health and social care settings, support for managing change and bringing innovation to healthcare delivery.

5.36 The National Skills Academy for Social Care and the Department are working together to improve the quality of leadership in adult social care. The Department of Health launched the Social Care Leadership Qualities Framework in October 2012 to help drive high quality, integrated care. The National Skills Academy is developing assessment tools that can be used in conjunction with the Framework that will help manager's identify where they can improve. The Department is also setting up a Leadership Forum, chaired by the Minister of State for Care and Support, that will seek to bring a fresh vision and impetus to leadership in social care. The Forum will bring together expertise from the best inspirational leaders from the private, public and voluntary sectors to develop the transformational leadership required. The National Skills Academy, in conjunction with the Department, has developed a support programme for front line, registered managers.

5.37 The Professional Standards Authority for Health and Social Care in November 2012 published *Standards for Members of NHS boards and Clinical Commissioning Bodies Governing Bodies*[20] that put respect, compassion and care for patients at the heart of leadership and good governance in the NHS. This for the first time brings together the essential skills that are expected of all NHS executive and non–executive leaders providing the basis for individuals to take responsibility for their own behaviour and challenge the behaviour of others.

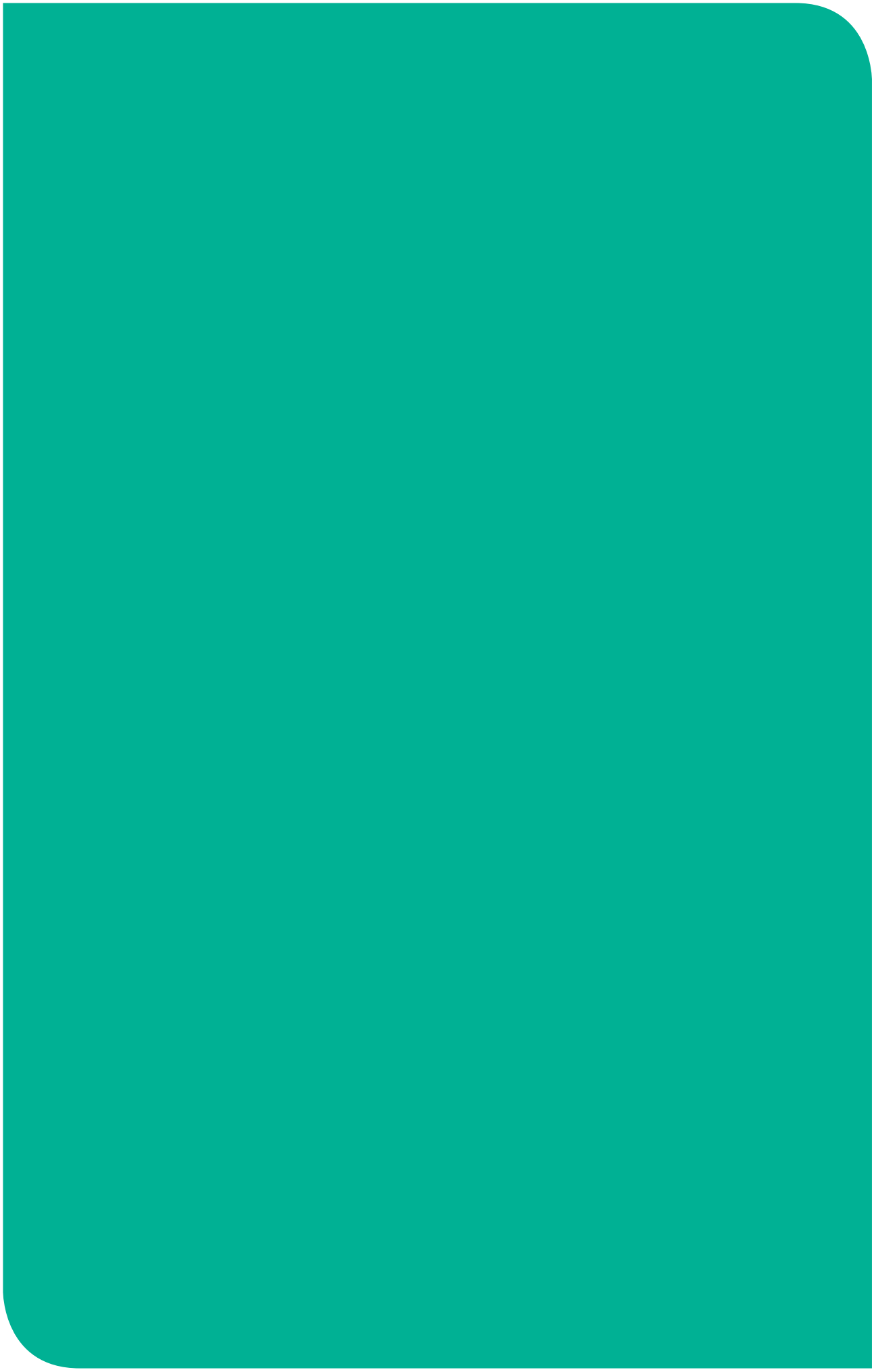
5.38 Many of the measures set out in this document make significant changes to the development and oversight arrangements for senior managers. In taking each measure forward, we will have in mind the cumulative impact on non-executive leaders, and will seek to ensure that the arrangements enable the NHS to attract and retain high quality non-executives from all walks of life.

5.39 We are transforming nursing, building and strengthening leadership at every level of the health and social care system. Through implementation of *Compassion in Practice*, this includes creating a system of accreditation for leaders in nursing, reviewing the role and function of Directors of Nursing, and appointing more former nurses as non-executive directors. A network of caremakers, who are students and newly qualified nurses and midwives, will promote the values of the "6Cs" and *Compassion in Practice*.

Frontline Experience for Department of Health Staff – Culture Change Within The Department of Health and Across the System

5.40 The need for cultural change applies equally to the Department of Health and other national bodies across the health and care systems. The behaviour of the Department has an important impact on the culture of the health and care system. We need to inspire everyone within the Department to model the same caring values and behaviours that we seek to foster across the wider system. This means ensuring that we build a healthy, open organisational culture within the Department and beyond.

5.41 The Department is reflecting on how to respond to this challenge. We understand that a sustained programme of organisational development is needed, with authentic commitment from senior leadership. At the same time, there are things we are doing right now to kick start change. We are considering how to ensure that clinical advice is at the heart of the Department's work. As recommended by Robert Francis, we are developing a structured programme of activities to help Department of Health staff reconnect to frontline staff and service users. Within four years, every civil servant in the Department will have sustained and meaningful experience of the frontline with the Senior Civil Service and Ministers leading the way.

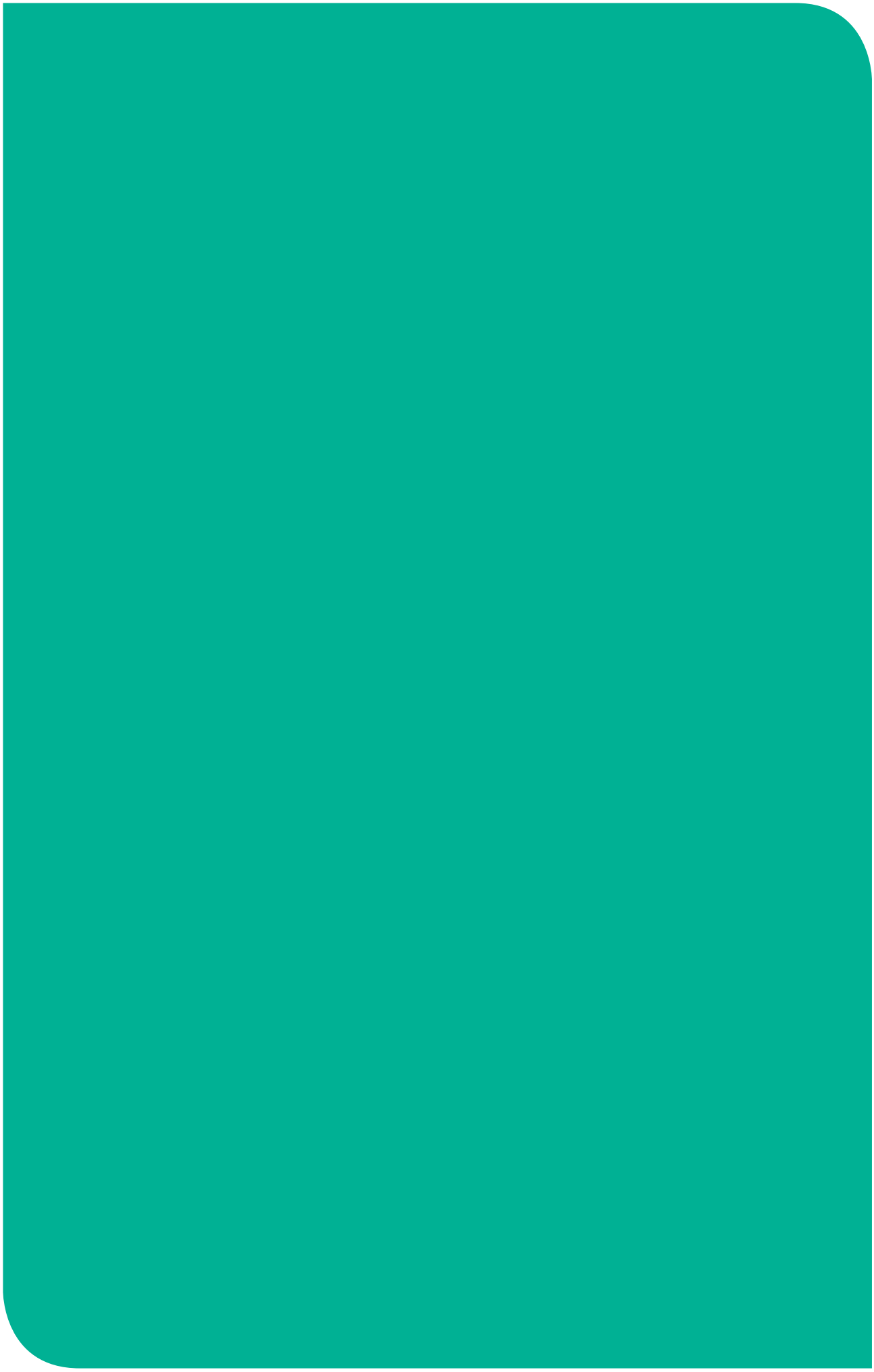


Conclusion

The measures set out in this document represents the Government's initial response to the key elements of Robert Francis' recommendations. Over the coming months and year we will consider the recommendations further and set out our intentions.

The Department of Health will be consulting on many of the measures set out here to ensure that in their detailed design and implementation they continue to reflect the spirit of the Inquiry, putting patients first and foremost.

Whilst these national measures will provide a new and powerful framework to assure safe, effective and respectful care, consistently and compassionately given, to have real effect, it will be for every board, every ward and every member of staff to reflect on what they can do to ensure this, drawing on their best instincts and their professional values. As Robert Francis has made clear, the NHS and its staff do not need to wait for Government to act to make the aims of his Inquiry a reality. That work can, and must, start now.



References

1. *Transforming Care: A national response to Winterbourne View Hospital*, Department of Health *(December 2012)*
2. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, chaired by Robert Francis QC. See http://www.midstaffspublicinquiry.com/report
3. *Compassion in Practice, Nursing, Midwifery and Care Staff. Our Vision and Strategy,* Jane Cummings, the Chief Nursing Officer for England (CNO), NHS Commissioning Board, and Viv Bennett, Director of Nursing at the Department of Health (December 2012). See http://www.commissioningboard.nhs.uk/files/2012/12/compassion-in-practice.pdf
4. *The Power of Information*, Department of Health (May 2012). See http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134205.pdf
5. *The Healthy NHS Board, A review of guidance and research evidence*, Angus Ramsay, Naomi Fulop, Adrienne Fresko and Sue Rubenstein (2010). See http://www.kingspssq.org.uk/assets/files/the_healthy_nhs_board_literature_review_13052010.pdf
6. *NHS Constitution* (March 2013), see http://www.dh.gov.uk/nhsconstitution
7. *Nuffield Publication Rating providers for quality: A policy worth reviewing?* Nuffield Trust (March 2013). See http://www.nuffieldtrust.org.uk/sites/files/nuffield/130322_ratings_providers_for_quality_full_report.pdf
8. *Review of Early Warning Systems in the NHS, Acute and Community Services,* National Quality Board (2010). See http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113021.pdf
9. *Quality in the New Health System – Maintaining and improving quality from April 2013*, National Quality Board (January 2013). See https://www.wp.dh.gov.uk/publications/files/2013/01/Final-NQB-report-v4-160113.pdf
10. *Bringing Clarity to Quality in Care and Support*, Department of Health (July 2012). See http://www.dh.gov.uk/health/files/2012/07/2900021-BCTQTLAP-2012-07-11-V3.pdf
11. *The Mandate, A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015*, Department of Health (November 2012). See http://publications.dh.gov.uk/files/2012/11/mandate.pdf
12. Mid Staffordshire NHS Foundation Trust Public Inquiry, see http://www.midstaffspublicinquiry.com

13. *Being Open: communicating patient safety incidents with patients, their families and carers*, National Patient Safety Association (2009) see http://www.nrls.npsa.nhs.uk/alerts/?entryid45=65077

14. *Caring for Our Future: reforming care and support*, Department of Health (July 2012). http://www.dh.gov.uk/health/files/2012/07/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf

15. *Strategic Review of the Nursing and Midwifery Council, Final Report*, Council for Healthcare Regulatory Excellence (July 2012). See http://www.ukipg.org.uk/meetings/professional_regulation_working_party/120702_CHRE_Final_Report_for_NMC_strategic_review_(pdf)_1.pdf

16. *Employee Engagement and NHS Performance*. Michael A West and Jeremy F Dawson (2012). See, http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

17. *Culture and behaviour in the English National Health Service from the blunt end to the sharp end: findings from a large multi-method study.* Mary Dixon-Woods, Richard Baker, Kathryn Charles *et al* (2013). Submitted for publication.

18. *Breaking down barriers, driving up standards, The role of the ward sister and charge nurse.* Royal College of Nursing (2009). See http://www.rcn.org.uk/__data/assets/pdf_file/0010/230995/003312.

19. *Making the business case for ward sisters/team leaders to be supervisory to practice*, Royal College of Nursing (2011). See http://www.rcn.org.uk/__data/assets/pdf_file/0005/414536/004188.pdf

20. *Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England.* Professional Standards Authority (November 2012). See, http://www.professionalstandards.org.uk/docs/psa-library/november-2012---standards-for-board-members.pdf?sfvrsn=0

Published by TSO (The Stationery Office) and available from:

Online
www.tsoshop.co.uk

Mail, Telephone, Fax & E-mail
TSO
PO Box 29, Norwich NR3 1GN
Telephone orders/General enquiries: 0870 600 5522
Order through the Parliamentary Hotline Lo-Call: 0845 7 023474
Fax orders: 0870 600 5533
Email: customer.services@tso.co.uk
Textphone: 0870 240 3701

The Houses of Parliament Shop
12 Bridge Street, Parliament Square
London SW1A 2JX
Telephone orders: 020 7219 3890/General enquiries: 020 7219 3890
Fax orders: 020 7219 3866
Email: shop@parliament.uk
Internet: http://www.shop.parliament.uk

TSO@Blackwell and other accredited agents

ISBN 978-0-10-185762-8