NHS Commissioning Board

NHSCB28021

BOARD PAPER - NHS COMMISSIONING BOARD

Title: Report of the Mid Staffordshire NHS Foundation Trust public inquiry
Clearance: Bill McCarthy, National Director: Policy
Purpose of Paper: • To provide an initial overview for the Board of the implications of the Mid Staffordshire Report for the NHS Commissioning Board (NHS CB).
Key Issues and Recommendations: • This paper provides an overview of the implications of the report of the Mid Staffordshire NHS Foundation Trust public inquiry. It summarises the themes of the report, explains how the NHS Commissioning Board will develop its response, and sets out the process for doing this. • The annex to this paper sets out an initial analysis of the report's recommendations under four categories; and
Actions Required by Board Members: • To welcome the publication of the public inquiry report. • To note the recommendations set out in Annex A. • To approve the proposed approach to developing the NHS CB's detailed response.

Report of the Mid Staffordshire NHS Foundation Trust public inquiry

Executive Summary

1. This paper provides an overview of the implications of the report of the Mid Staffordshire NHS Foundation Trust public inquiry. It summarises the themes of the report, explains how the NHS Commissioning Board will develop its response, and sets out the process for doing this.

2. The report sets out 290 recommendations. Its overarching theme is that a fundamental culture change is needed in the NHS to put patients first. The recommendations cover five broad areas, highlighting the need for:

   - a structure of fundamental standards and measures of compliance;
   - openness, transparency and candour throughout the system underpinned by statute;
   - improved support for caring, compassionate, and considerate nursing;
   - stronger healthcare leadership; and
   - accurate, useful and relevant information.

3. The NHS CB will review all aspects of its work programme to identify what more needs to be done to address the Francis recommendations, building on a range of actions which are already in hand. As the first step in this process, the annex to this paper sets out an initial analysis of the report's recommendations under four categories;

   - those for which the NHSCB has lead responsibility;
   - those which are subject to policy decisions by Government;
   - those which require action by all organisations; and
   - those which fall to other organisations..

4. The NHS CB's Executive Team will act as the overarching governance group for the response. It will be supported by a matrix working group, with representation from all parts of the organisation.

5. Members of the Board are requested to:

   - welcome the publication of the public inquiry report;

   - note the recommendations set out in Annex A;

   - approve the proposed approach to developing the NHS CB's detailed response.

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Introduction

1. This paper provides an initial overview for the Board of the implications for the NHS CB of the report of the Mid Staffordshire NHS Foundation Trust public inquiry. It summarises the themes of the report, explains how the NHS Commissioning Board (NHS CB) will develop its considered response, and sets out the process for doing this.

Background

2. The previous government ordered an independent inquiry, led by Robert Francis QC, into failings in the quality of care at Mid Staffs between 2005 and 2009. The independent inquiry reported in 2010 and made a number of recommendations for change in the Trust and the wider NHS.

3. When the coalition government came to power, the Secretary of State, Andrew Lansley, asked Robert Francis to undertake a further inquiry into the role of the wider NHS system in the failures at the Trust, particularly the commissioning, regulatory and supervisory bodies. The report of this formal public inquiry was published on 6 February.

The Report of the Public Inquiry

4. The Francis Report is presented in three volumes, which run to 1782 pages, together with an executive summary. It tells the story of appalling suffering of many patients, primarily caused by a serious failure on the part of a Trust Board which did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. It failed to tackle a culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities.

5. The report refers to the many checks and balances in the NHS system which should have prevented serious systemic failure of this sort but did not. A system which ought to have picked up and dealt with a deficiency of this scale failed in its primary duty to protect patients and maintain confidence in the healthcare system. The report identifies numerous warning signs which should have alerted the system to the problems developing at the Trust.

6. Francis has said clearly that it should be patients, not numbers, which count. The requirement for financial control, corporate governance, commissioning and regulatory systems may be necessary, but it is not the system itself which will ensure that the patient is put first day in and day out.

7. The report sets out 290 recommendations but its single, overarching theme is clear: that a fundamental culture change is needed in the NHS to put patients first. Robert Francis highlighted five themes when he presented his report. These covered the need for:

- a structure of fundamental standards and measures of compliance;
- openness, transparency and candour throughout the system underpinned by statute;
- improved support for caring, compassionate, and considerate nursing;
- stronger healthcare leadership; and
- accurate, useful and relevant information.

8. The report recommends that every NHS organisation should set out as soon as practicable the extent to which it accepts the report's recommendations; what it intends to do to implement them; and to publish a report on progress at least once a year.

Developing the NHS CB's Response

9. In view of the number and scope of the report's recommendations, it is too early to make a comprehensive assessment of its implications for the work of the NHS CB. However, the Board has a duty to ensure the provision of a comprehensive health service and a duty to secure continuous quality improvement. It is committed to promoting and upholding the values, rights and pledges enshrined within the NHS Constitution and to promoting equality and reducing health inequalities, putting patients and the public at the heart of everything it does.

10. How the NHS CB responds to the Francis Report will be both a test of these duties and commitments and an opportunity for the Board to work with its partners to drive the required cultural change in the NHS.

11. This raises important implications for how the Board shapes its work programme. In particular, it will be important to consider:

- how the report's key themes and recommendations will be addressed through delivery of the NHS CB's core business with the NHS and partner organisations;

- how the cultural change recommended by Francis will be embedded in the development of the NHS CB itself; and

- the implications for the way the Board itself conducts its business.

12. The NHS CB already has a good deal of work under way which is in line with the Francis Report recommendations. Key examples include:

- a range of actions and commitments made in the NHS CB's planning guidance, *Everyone Counts*;

- the development of the authorisation process for CCGs with a clear focus on quality, shaped by the first Francis report;

- the NHS CB plan to respond to the final report on Winterbourne View;

- the publication of the Chief Nursing Officer's vision and strategy for Nursing, *Compassion in Practice;*

- the development of the NHS CB's Business Plan for 2013/14;

- the implementation of the NHS CB's Organisation Development Strategy, as a key driver of cultural change;

- hosting on behalf of the wider NHS system the National Quality Board and the NHS Leadership Academy, which will play key roles in shaping the new culture; and

- developing a comprehensive vision for patient safety over the next few months, with the support of Don Berwick, a well-respected US expert in patient safety and healthcare quality improvement.

13. In addition the NHS CB is providing support for Sir Bruce Keogh's investigation, in his capacity as NHS Medical Director, into hospitals which are outliers on measures of mortality;

14. However, these actions are only the start of a much more comprehensive response to the report. Every aspect of the Board's work programme will now be reviewed to identify what more needs to be done. As the first step in this process, the annex to this paper sets out :an initial analysis of the report's recommendations under four categories:

    - those for which the NHSCB has lead responsibility;
    - those which are subject to policy decisions by Government;
    - those which require action by all organisations; and
    - those which fall to other organisations.

15. The categories used in Annex A represent only an initial view. They will be tested with partner organisations and further refined. The NHS CB will contribute fully to the system response to the full range of recommendations as well as acting on those for which it has lead responsibility.

Timescales

16. In welcoming the Francis Report, the Prime Minister indicated that the Government would respond to its recommendations before the end of March. The NHS CB will work with the Department of Health and other partners to support the development of the Government's response.

17. It is proposed that the NHS CB should align its own initial plan with the Government response. By the end of March it will set out in outline terms how it will address each of the recommendations for which it has lead responsibility.

18. By July it will then publish a more detailed action plan setting out how the actions will be implemented.

Programme Management and Governance

19. The Board will receive reports at each meeting on progress with the actions to respond to the Francis recommendations, to assure itself that it is driving the cultural changes required. The Board is committed to transparency and openness, holding all of its meetings in public. It will receive information, through the corporate dashboard, which provides a clear focus on quality and safety and on the things which matter most to patients.

20. Bill McCarthy, National Director: Policy, will act as the lead national director for co-ordinating the NHS CB response. Jane Cummings, Chief Nursing Officer, will have the overall clinical lead. However, each directorate in the NHS CB's national support centre, and every regional and area team will also have a key role to play in the response.

21. By its very nature, the response cannot be managed as a discrete project or programme. Rather, it must encompass all of the Board's key products and business processes, and the ways in which it operates. In light of this, the NHS CB's Executive Team will act as the overarching governance group for the response. This will be supported by a matrix working group with representation from all parts of the organisation.

22. Through this matrix working approach the five domains of the NHS Outcomes Framework will be placed at the heart of the NHS CB response, ensuring that it is entirely focused on improving outcomes for patients. This approach will be underpinned by the corporate programme management office.

Recommendation

23. Members of the Board are requested to:

- welcome the publication of the public inquiry report;
- note the recommendations set out in **Annex A**;
- approve the proposed approach to developing the NHS CB's detailed response.

Bill McCarthy, National Director: Policy
Feburary 2013

Annex A

Initial analysis of the report's recommendations

Action	Recommendation no. and description	Chapter
1) Recommendations for which NHS CB has lead responsibility	**13.** Standards should be divided into: • Enhanced quality standards – such standards could set requirements higher than the fundamental standards but be discretionary matters for commissioning and subject to availability of resources; • Developmental standards which set out longer term goals for providers – these would focus on improvements in effectiveness and are more likely to be the focus of commissioners and progressive provider leadership than the regulator. All such standards would require regular review and modification.	21
	17. The NHS Commissioning Board together with Clinical Commissioning Groups should devise enhanced quality standards designed to drive improvement in the health service. Failure to comply with such standards should be a matter for performance management by commissioners rather than the regulator, although the latter should be charged with enforcing the provision by providers of accurate information about compliance to the public.	21
	42. Strategic Health Authorities/their successors should, as a matter of routine, share information on serious untoward incidents with the Care Quality Commission.	11
	77. Monitor and the NHS Commissioning Board should review the resources and facilities made available for the training and development of governors to enhance their independence and ability to expose and challenge deficiencies in the quality of the foundation trust's services.	10
	91. The Department of Health and NHS Commissioning Board should consider what steps are necessary to require all NHS providers, whether or not they remain members of the NHS Litigation Authority scheme, to have and to comply with risk management standards at least as rigorous as those required by the NHS Litigation Authority.	15
	97. The National Patient Safety Agency's resources need to be well protected and defined. Consideration should be given to the transfer of this valuable function to a systems regulator.	17
	98. Reporting to the National Reporting and Learning System of all significant adverse incidents	17

Action	Recommendation no. and description	Chapter
	not amounting to serious untoward incidents but involving harm to patients should be mandatory on the part of trusts.	
	99. The reporting system should be developed to make more information available from this source. Such reports are likely to be more informative than the corporate version where an incident has been properly reported, and invaluable where it has not been.	17
	100. Individual reports of serious incidents which have not been otherwise reported should be shared with a regulator for investigation, as the receipt of such a report may be evidence that the mandatory system has not been complied with.	17
	101. While it may be impracticable for the National Patient Safety Agency or its successor to have its own team of inspectors, it should be possible to organise for mutual peer review inspections or the inclusion in Patient Environment Action Team representatives from outside the organisation. Consideration could also be given to involvement from time to time of a representative of the Care Quality Commission.	17
	102. Data held by the National Patient Safety Agency or its successor should be open to analysis for a particular purpose, or others facilitated in that task.	17
	103. The National Patient Safety Agency or its successor should regularly share information with Monitor.	17
	104. The Care Quality Commission should be enabled to exploit the potential of the safety information obtained by the National Patient Safety Agency or its successor to assist it in identifying areas for focusing its attention. There needs to be a better dialogue between the two organisations as to how they can assist each other.	17
	105. Consideration should be given to whether information from incident reports involving deaths in hospital could enhance consideration of the hospital standardised mortality ratio.	17
	123. GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services. They should be an independent, professionally qualified check on the quality of service, in particular in relation to an assessment of outcomes. They need to have internal systems enabling them to be aware of patterns of concern, so that they do	7

Action	Recommendation no. and description	Chapter
	not merely treat each case on its individual merits. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice reality. A GP's duty to a patient does not end on referral to hospital, but is a continuing relationship. They will need to take this continuing partnership with their patients seriously if they are to be successful commissioners.	
	124. The commissioner is entitled to and should, wherever it is possible to do so, apply a fundamental safety and quality standard in respect of each item of service it is commissioning. In relation to each such standard, it should agree a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance by requiring redress for individual patients who have received substandard service to be offered by the provider. These must be consistent with fundamental standards enforceable by the Care Quality Commission.	7
	125. In addition to their duties with regard to the fundamental standards, commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards. They can incentivise higher standards either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work.	7
	126. The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups are formed, and guidance for commissioners on what they should expect to see in any organisational transitions among their providers.	7
	127. The NHS Commissioning Board and local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of its providers' services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.	7
	128. Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement expertise.	7

Action	Recommendation no. and description	Chapter
	129. In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed.	7
	130. Commissioners – not providers – should decide what they want to be provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers and from elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail.	7
	131. Commissioners need, wherever possible, to identify and make available alternative sources of provision. This may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with providers.	7
	132. Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period: • Such monitoring may include requiring quality information generated by the provider. • Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases. • The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation. • Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving the healthcare regulator to focus on fundamental standards.	7
	133. Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.	7

Action	Recommendation no. and description	Chapter
	135. Commissioners should be accountable to their public for the scope and quality of services they commission. Acting on behalf of the public requires their full involvement and engagement: • There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners. [Need to work with DH on this aspect] • There should be lay members of the commissioner's board. • Commissioners should create and consult with patient forums and local representative groups. Individual members of the public (whether or not members) must have access to a consultative process so their views can be taken into account. • There should be regular surveys of patients and the public more generally. • Decision-making processes should be transparent: decision-making bodies should hold public meetings. Commissioners need to create and maintain a recognisable identity which becomes a familiar point of reference for the community.	7
	136. Commissioners need to be recognisable public bodies, visibly acting on behalf of the public they serve and with a sufficient infrastructure of technical support. Effective local commissioning can only work with effective local monitoring, and that cannot be done without knowledgeable and skilled local personnel engaging with an informed public.	7
	138. Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found that they are at risk from substandard or unsafe services.	7
	139. The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with.	8
	140. Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including information about its judgement as to the safety of patients of the healthcare provider.	8
	141. Any differences of judgement as to immediate safety concerns between a performance	8

Action	Recommendation no. and description	Chapter
	manager and a regulator should be discussed between them and resolved where possible, but each should recognise its retained individual responsibility to take whatever action within its power is necessary in the interests of patient safety.	8
	142. For an organisation to be effective in performance management, there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality.	8
	143. Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	8
	144. The NHS Commissioning Board should ensure the development of metrics on quality and outcomes of care for use by commissioners in managing the performance of providers, and retain oversight of these through its regional offices, if appropriate.	23 (CNO)
	196. The Knowledge and Skills Framework should be reviewed with a view to giving explicit recognition to nurses' demonstrations of commitment to patient care and ,in particular, to the priority to be accorded to dignity and respect, and their acquisition of leadership skills.	23
	198. Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the culture health of front-line nursing workplace and teams, which build on the experience and feedback of nursing staff using a robust methodology, such as the "cultural barometer".	23
	203. A forum for all directors of nursing from both NHS and independent sector organisation should be formed to provide a means for coordinating the leadership of the nursing profession.	23
	205. Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.	23
	208. Commissioning arrangements should require provider organisations to ensure by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that	

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	of a registered nurse.	
	214. A leadership staff college or training system, whether centralised or regional, should be created to; provide common professional training in management and leadership to potential senior staff; promote healthcare considering for such roles; promote and research best leadership practice in healthcare.	24
	216. The leadership framework should be improved by increasing the emphasis given to patient safety in the thinking of all in the health service. This could be done by, for example, creating a separate domain for managing safety, or by defining the service to be delivered as a safe and effective service.	24
	217. A list should be drawn up of all the qualities generally considered necessary for a good and effective leaders. This in turn could inform a list of competencies a leader would be expected to have.	23
	220. A training facility could provide the route through which an accreditation scheme could be organised. Although this might be a voluntary scheme, at least initially, the objective should be to require all leadership posits to be filled by persons who experience some shared training and obtain the relevant accreditation, enhancing the spread of the common culture and providing the basis for a regulatory regime.	24
	244. There is a need for all to accept common information practices, and to feed information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should be designed to include prompts and defaults where this will contribute to safe and effective care, and to accurate recording of information on first entry. • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised	26

Action	Recommendation no. and description	Chapter
	direct from entries to avoid unnecessary duplication of input. • Systems should be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. Systems should be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.	
	246. Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality account should be required to contain the observations of commissioners, overview and scrutiny committees and Local Healthwatch.	26
	252. It is important that the appropriate steps are taken to enable properly anonymised data to be used for managerial and regulatory purposes.	26
	253. The information behind the quality and risk profile – as well as the ratings and methodology – should be placed in the public domain, as far as is consistent with maintaining any legitimate confidentiality of such information, together with appropriate explanations to enable the public to understand the limitations of this tool.	26
	254. While there are likely to be many different gateways offered through which patient and public comments can be made, to avoid confusion, it would be helpful for there to be consistency across the country in methods of access, and for the output to be published in a manner allowing fair and informed comparison between organisations.	26
	264. In the case of each specialty, a programme of development for statistics on the efficacy of treatment should be prepared, published, and subjected to regular review.	26
	265. The Department of Health, the Information Centre and the Care Quality Commission should engage with each representative specialty organisation in order to consider how best to develop comparative statistics on the efficacy of treatment in that specialty, for publication and use in	

Action	Recommendation no. and description	Chapter
	performance oversight, revalidation, and the promotion of patient knowledge and choice. **266.** In designing the methodology for such statistics and their presentation, the Department of Health, the Information Centre, the Care Quality Commission and the specialty organisations should seek and have regard to the views of patient groups and the public about the information needed by them. **267.** All such statistics should be made available online and accessible through provider websites, as well as other gateways such as the Care Quality Commission.	26 26
2) Recommendations which are subject to policy decisions by Government	**13.** Standards should be divided into: • Fundamental standards of minimum safety and quality – in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. There should be a defined set of duties to maintain and operate an effective system to ensure compliance; **15.** All the required elements of governance should be brought together into one comprehensive standard. This should require not only evidence of a working system but also a demonstration that it is being used to good effect. **16.** The Government, through regulation, but after so far as possible achieving consensus between the pubic and professional representatives, should provide for the fundamental standards which should define outcomes for patients that must be avoided. These should be limited to those matters that it is universally accepted should be avoided for individual patients who are accepted for treatment by a healthcare provider. **18.** It is essential that professional bodies in which doctors and nurses have confidence are fully involved in the formulation of standards and in the means of measuring compliance. **19.** There should be a single regulator dealing both with corporate governance, financial compliance with patient safety and quality standards for all trusts. **20.** The Care Quality Commission should be responsible for policing the fundamental standards, through the development of its core outcomes, by specifying the indicators by which it intends to monitor compliance with those standards. It should be responsible not for directly policing	21 11 21 21 10 21

Action	Recommendation no. and description	Chapter
	compliance with any enhanced standards but for regulating the accuracy of information about compliance with them.	
	21. The regulator should have a duty to monitor the accuracy of information disseminated by providers and commissioners on compliance with standards and their compliance with the requirement of honest disclosure. The regulator must be willing to consider individual cases of gross failure as well as systemic causes for concern.	21
	22. The National Institute for Health and Clinical Excellence should be commissioned to formulate standard procedures and practice designed to provide the practical means of compliance, and indicators by which compliance with both fundamental and enhanced standards can be measured. These measures should include both outcome and process based measures, and should as far as possible build on information already available within the system or on readily observable behaviour.	21
	23. The measures formulated by the National Institute for Health and Clinical Excellence should include measures not only of clinical outcomes, but of the suitability and competence of staff, and the culture of organisations. The standard procedures and practice should include evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. This should include nursing staff on wards, as well as clinical staff. These tools should be created after appropriate input from specialties, professional organisations, and patient and public representatives, and consideration of the benefits and value for money of possible staff: patient ratios.	21
	24. Compliance with regulatory fundamental standards must be capable so far as possible of being assessed by measures which are understood and accepted by the public and healthcare professionals.	21
	25. It should be considered the duty of all specialty professional bodies, ideally together with the National Institute for Health and Clinical Excellence, to develop measures of outcome in relation to their work and to assist in the development of measures of standards compliance.	21
	26. In policing compliance with standards, direct observance of practice, direct interaction with patients, carers and staff, and audit of records should take priority over monitoring and audit of	9

Action	Recommendation no. and description	Chapter
	policies and protocols. The regulatory system should retain the capacity to undertake in-depth investigations where these appear to be required.	
	27. The healthcare systems regulator should promote effective enforcement by: use of a low threshold of suspicion; no tolerance of non-compliance with fundamental standards; and allowing no place for favourable assumptions, unless there is evidence showing that suspicions are ill-founded or that deficiencies have been remedied. It requires a focus on identifying what is wrong, not on praising what is right.	9
	28. Zero tolerance: A service incapable of meeting fundamental standards should not be permitted to continue. Brach should result in regulatory consequences attributable to an organisation in the case of a system failure and to individual accountability where individual professionals are responsible. Where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards, criminal liability should follow and failure to disclose breaches of these standards to the affected patient (or concerned relative) and a regulator should also attract regulatory consequences. Breaches not resulting in actual harm but which have exposed patients to a continuing risk of harm to which they would not otherwise have been exposed should also be regarded as unacceptable.	21
	30. The healthcare regulator must be free to require or recommend immediate protective steps where there is reasonable cause to suspect a breach of fundamental standards, even if it has yet to reach a concluded view or acquire all the evidence. The test should be whether it has reasonable grounds in the public interest to make the interim requirement or recommendation.	9
	33. Insofar as healthcare regulators consider they do not possess any necessary interim powers, the Department of Health should consider introduction of the necessary amendments to legislation to provide such powers.	10
	34. Where a provider is under regulatory investigation, there should be some form of external performance management involvement to oversee any necessary interim arrangements for protecting the public.	9
	38. The Care Quality Commission should ensure as a matter of urgency that it has reliable access to all useful complaints information relevant to assessment of compliance with fundamental standards, and should actively seek this information out, probably via its local	11

Action	Recommendation no. and description	Chapter
	relationship managers. Any bureaucratic or legal obstacles to this should be removed.	
	39. The Care Quality Commission should introduce a mandated return from providers about patterns of complaints, how they were dealt with and outcomes.	11
	40. It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.	11
	53. Any change to the Care Quality Commission's role should be by evolution – any temptation to abolish this organisation and create a new one must be avoided.	11
	60. The Secretary of State should consider transferring the functions of regulating governance of healthcare providers and the fitness of persons to be directors, governors or equivalent persons from monitor to the Care Quality Commission.	11/10
	61. A merger of system regulatory functions between Monitor and the Care Quality Commission should be undertaken incrementally and after thorough planning. Such a move should not be used as a justification for reduction of the resources allocated to this area of regulatory activity. It would be vital to retain the corporate memory of both organisations.	11/10
	64. The authorisation process should be conducted by one regulator, which should be equipped with the relevant powers and expertise to undertake this effectively. With due regard to protecting the public from the adverse consequences inherent to any reorganisation, the regulation of the authorisation process and compliance with foundation trust standards should be transferred to the Care Quality Commission, which should incorporate the relevant departments of Monitor.	4
	109. Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.	3
	110. Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to	3

Action	Recommendation no. and description	Chapter
	respond to complaints should be regarded as entirely separate from the considerations of litigation.	
	113. The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	3
	134. Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.	7
	137. Commissioners should have powers of intervention where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from the risk of harm. In the provision of the commissioned services, such powers should be aligned with similar powers of the regulators so that both commissioners and regulators can act jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop provision of a service.	7
	147. Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.	6
	178. The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations.	22
	182. There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation, where given in compliance with a statutory obligation on the organisation to provide it.	22
	185. There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires; • Selection of recruits to the professional who evidence the: – Possession of the appropriate values, attitudes and behaviours;	23

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	– Ability and motivation to enable them to put the welfare of others above their own interests; – Drive to maintain, develop and improve their own standards and abilities; – Intellectual achievements to enable them to acquire through training and necessary technical skills; • Training and experience in delivery of compassionate care; • Leadership which constantly reinforces values and standards of compassionate care; • Involvement in, and responsibility for, the planning and delivery of compassionate care; • Constant support and incentivisation which values nurses and the work they do through: – Recognition and achievement; – Regular, comprehensive feedback on performance and concerns; – Encouraging them to report concerns and to give priority to patient well-being.	
	186. Nursing training should be reviewed so that sufficient practical elements are incorporated to ensure that a consistent standard is achieved by all trainees throughout the country. This requires national standards.	23
	188. The Nursing and Midwifery Council, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates' attitudes towards caring, compassion and other necessary professional values.	23
	189. The Nursing and Midwifery Council and other professional and academic bodies should work towards a common qualification assessment/examination.	23
	190. There should be national training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of the fundamental aspects of compassionate care.	23
	197. Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff.	23

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	200. Consideration should be given to the creation of a status of Registered Older Person's Nurse.	23
	204. All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors.	23
	206. The effectiveness of the newly positioned office of /chief Nursing Officer should be kept under review to ensure the maintenance of a recognised leading representative of the nursing profession as a whole, able and empowered to give independent professional advice to the government on nursing issues of equivalent authority to that provided by the Chief Medical Officer.	23
	207. There should be a uniform description of healthcare support workers, with the relationship with currently registered nurses made clear by the title.	23
	209. A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability and/or infirmity) in a hospital or care home setting. The system should apply to healthcare support workers, whether they are working for the NHS or independent healthcare providers, in the community, for agencies or as independent agents. (Exemptions should be made for persons caring for members of their own family or those with whom they have a genuine social relationship.)	23
	210. There should be a national code of conduct for healthcare support workers.	23
	211. There should be a common set of national standards for the education and training of healthcare support workers.	23
	212. The code of conduct, education and training standards and requirements for registration for healthcare support workers should be prepared and maintained by the Nursing and Midwifery Council after due consultation with all relevant stakeholders, including the Department of Health, other regulators, professional representative organisations and the public.	23

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	215. A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.	24
	218. Serious non-compliance with the code, and in particular, non-compliance leading to actual or potential harm to patents, should render board-level leaders and managers liable to be found not to be fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them from holding such positions in future.	24
	219. An alternative option to enforcing compliance with a management code of conduct, with the risk of disqualification, would be to set up an independent professional regulator. The need for this would be greater if it were thought appropriate to extend a regulatory requirement to wider range of managers and leaders. The proportionality of such a step could be better assessed after reviewing the experience of a licensing provision of directors.	24
	221. Consideration should be given to ensuring that there is regulatory oversight of the competence and compliance with appropriate standards by the boards of health and service bodies which are not foundation trusts, of equivalent rigour to that applied to foundation trusts.	24
	247. Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, local Healthwatch, and all systems regulators.	26
	257. The Information Centre should be tasked with the independent collection, analysis, publication and oversight of healthcare information in England, or, with the agreement of the devolved governments, the United Kingdom. The information functions previously held by the National Patient Safety Agency should be transferred to the NHS Information Centre if made independent.	26
	259. The Information Centre, in consultation with the Department of Health, the NHS Commissioning Board and the Parliamentary and Health Service Ombudsman, should develop a means of publishing more detailed breakdowns of clinically related complaints.	26
	260. The standards applied to statistical information about serious untoward incidents should be the same as for any other healthcare information and in particular the principles around	26

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	transparency and accessibility. It would, therefore, be desirable for the data to be supplied to, and processed by, the Information Centre and, through them, made publicly available in the same way as other quality related information.	
	261. The Information Centre should be enabled to undertake more detailed statistical analysis of its own than currently appears to be the case.	26
	270. There is a need for a review by the Department of Health, the Information Centre and the UK Statistics Authority of the patient outcome statistics, including hospital mortality and other outcome indicators. In particular, there could be benefit from consideration of the extent to which these statistics can be published in a form more readily useable by the public.	26
	271. To the extent that summary hospital-level mortality indicators are not already recognised as national or official statistics, the Department of Health and the Health and Social Care Information Centre should work towards establishing such status for them or any successor hospital mortality figures, and other patient outcome statistics, including reports showing provider-level detail.	26
	286. Impact and risk assessments should be made public, and debated publicly, before a proposal for any major structural change to the healthcare system is accepted. Such assessments should cover at least the following issues: • What is the precise issue or concern in respect of which change is necessary? • Can the policy objective identified be achieved by modifications within the existing structure? • How are the successful aspects of the existing system to be incorporated and continued in the new system? • How are the existing skills which are relevant to the new system to be transferred to it? • How is the existing corporate and individual knowledge base to be preserved, transferred and exploited? • How is flexibility to meet new circumstances and to respond to experience built into the new system to avoid the need for further structural change? • How are necessary functions to be performed effectively during any transitional period? • What are the respective risks and benefits to service users and the public and, in particular, are there any risks to safety or welfare?	19

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	287. The Department of Health should together with healthcare systems regulators take the lead in developing through obtaining consensus between the public and healthcare professionals, a coherent, and easily accessible structure for the development and implementation of values, fundamental, enhanced and developmental standards as recommended in this report. **288.** The Department of Health should ensure that there is senior clinical involvement in all policy decisions which may impact on patient safety and well-being.	19 19
3) Recommendations which apply to all organisations	**1.** It is recommended that: • All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them in their own work; • Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions; • In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by other organisations; • The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report. **2.** The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires: • A common set of core values and standards shared throughout the system; • Leadership at all levels from ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards; • A system which recognises and applies the values of transparency, honesty and candour; • Freely available, useful, reliable and full information on attainment of the values and standards;	Introduction 20

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	• A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system.	21
	4. The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	21
	7. All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.	21
	8. Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services.	20
	11. Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and pathways as possible.	2
	12. Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	9
	14. In addition to the fundamental standards of service, the regulations should include generic requirements for a governance system designed to ensure compliance with fundamental standards, and the provision and publications of accurate information about compliance with the fundamental and enhanced standards.	21
	29. It should be an offence for death or serious injury to be caused to a patient by a breach of	

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	these regulatory requirements, or, in any other case of breach, where a warning notice in respect of the breach has been served and the notice has not been complied with. It should be a defence for the provider to prove that all reasonably practicable steps have been taken to prevent a breach, including having in place a prescribed system to prevent such a breach.	
	31. Where aware of concerns that patient safety is at risk, Monitor and all other regulators of healthcare providers must have in place policies which ensure that they constantly review whether the need to protect patients requires use of their own powers of intervention to inform a decision whether or not to intervene, taking account of, but not being bound by, the views or actions of other regulators.	10
	32. Where patient safety is believed on reasonable grounds to be at risk, Monitor and any other regulator should be obliged to take whatever action within their powers is necessary to protect patient safety. Such action should include, where necessary, temporary measures to ensure such protection while any investigation required to make a final determination is undertaken.	10
	35. Sharing of intelligence between regulators needs to go further than sharing of existing concerns identified as risks. It should extend to all intelligence which when pieced together with that possessed by partner organisations may raise the level of concern. Work should be done on a template of the sort of information each organisation would find helpful.	9
	36. A coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real time as possible, and should be capable of use by regulators in assessing the risk of non-compliance. It must not only include statistics about outcomes, but must take advantage of all safety related information, including that capable of being derived from incidents, complaints and investigations.	9
	41. The Care Quality Commission should have a clear responsibility to review decisions not to comply with patient safety alerts and to oversee the effectiveness of any action required to implement them. Information-sharing with the Care Quality Commission regarding patient safety alerts should continue following the transfer of the National Patient Safety Agency's functions in June 2012 to the NHS Commissioning Board.	11
	43. Those charged with oversight and regulatory roles in healthcare should monitor media	6

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	reports about the organisations for which they have responsibility.	
	44. Any example of a serious incident or avoidable harm should trigger and examination by the Care Quality Commission of how that was addressed by the provider and a requirement for the trust concerned to demonstrate that the learning to be derived has been successfully implemented.	11
	68. No NHS trust should be given support to make an application to Monitor unless, in addition to other criteria, the performance manager (the Strategic Health Authority cluster, the Department of health team, or the NHS Trust Development Authority) is satisfied that the organisation currently meets Monitor's criteria for authorisation and that it is delivering a sustainable service which is, and will remain, safe for patients, and is compliant with at least fundamental standards.	4
	114. Comments or complaints which describe events amounting to a serious or untoward incident should trigger an investigation.	3
	118. Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.	3
	122. Large-scale failures of clinical service are likely to have in common a need for: • Provision of prompt advice, counselling and support to very distressed and anxious members of the public; • Swift identification of persons of independence, authority and expertise to lead investigations and reviews; • A procedure for the recruitment of clinical and other experts to review cases; • A communications strategy to inform and reassure the public of the processes being adopted; • Clear lines of responsibility and accountability for the setting up and oversight of such reviews. Such events are of sufficient rarity and importance, and requiring of coordination of the activities of multiple organisations, that the primary responsibility should reside in the National Quality	3

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	Board.	18
	152. Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.	18
	153. The Secretary of State should by statutory instrument specify all medical education and training regulators as relevant bodies for the purpose of their statutory duty to cooperate. Information sharing between the deanery, commissioners, the General Medical Council, the Care Quality Commission and Monitor with regard to patient safety issues must be reviewed to ensure that each organisation is made aware of matters of concern relevant to their responsibilities.	18
	169. The Department of Health, through the National Quality Board, should ensure that procedures are put in place for facilitating the identification of patient safety issues by training regulators and cooperation between them and healthcare systems regulators.	22
	173. Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	22
	177. Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	22
	179. "Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	22
	180. Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.	23
	191. Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and	

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	regulatory requirements. **263.** It must be recognised to be the professional duty of all healthcare professionals to collaborate in the provision of information required for such statistics on the efficacy of treatment in specialties.	26
4) Recommendations for which other organisations have lead responsibility	**3.** The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations and obligations of patients.	21
	5. In reaching out to patients, consideration should be given to including expectations in the NHS Constitution that: • Staff put patients before themselves; • They will do everything in their power to protect patients from avoidable harm; • They will be honest and open with patients regardless of the consequences for themselves; • Where they are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so; • They will apply the NHS values in all their work.	21
	6. The handbook to the NHS Constitution should be revised to include a much more prominent reference to the NHS values and their significance.	21
	9. The NHS Constitution should include reference to all the relevant professional and managerial codes by which NHS staff are bound, including the Code of conduct for NHS Managers.	21
	10. The NHS Constitution should incorporate an expectation that staff will follow guidance and comply with standards relevant to their work, such as those produced by the National Institute for Health and Clinical Excellence and, where relevant, the Care Quality Commission, subject to any more specific requirements of their employers.	21
	37. Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them. To the extent that it is not practical in a written report to set out detail, this should be made available via each trust's website. Reports should no longer be confined to reports on	11

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	achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information. To make or be party to a wilfully or recklessly false statement as to compliance with safety or essential standards in the required quality account should be made a criminal offence.	11
	45. The Care Quality Commission should be notified directly of upcoming healthcare-related inquests, either by trusts or perhaps more usefully by coroners.	11
	46. The Quality and Risk Profile should not be regarded as a potential substitute for active regulatory oversight by inspectors. It is important that this is explained carefully and clearly as and when the public are given access to the information.	11
	47. The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information resource. For example, it should further develop its current 'sounding board events'.	11
	48. The Care Quality Commission should send a personal letter, via each registered body, to each foundation trust governor on appointment, inviting them to submit relevant information about any concerns to the Care Quality Commission.	11
	49. Routine and risk-related monitoring, as opposed to acceptance of self-declarations of compliance, is essential. The Care Quality Commission should consider its monitoring in relation to the value to be obtained from: • The Quality and Risk Profile; • Quality Accounts; • Reports from Local Healthwatch; • New or existing peer review schemes; • Themed inspections.	11
	50. The Care Quality Commission should retain an emphasis on inspection as a central method of monitoring non-compliance.	11
	51. The Care Quality Commission should develop a specialist cadre of inspectors by thorough training in the principles of hospital care. Inspections of NHS hospital care providers should be led by such inspectors who should have the support of a team, including service user	

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	representatives, clinicians and any other specialism necessary because of particular concerns. Consideration should be given to applying the same principle to the independent sector, as well as to the NHS.	11
	52. The Care Quality Commission should consider whether inspections could be conducted in collaboration with other agencies, or whether they can take advantage of any peer review arrangements available.	11
	54. Where issues relating to regulatory action are discussed between the Care Quality Commission and other agencies, these should be properly recorded to avoid any suggestion of inappropriate interference in the Care Quality Commission's statutory role.	11
	55. The Care Quality Commission should review its processes as a whole to ensure that it is capable of delivering regulatory oversight and enforcement effectively, in accordance with the principles outlined in this report.	11
	56. The leadership of the Care Quality Commission should communicate clearly and persuasively its strategic direction to the public and to its staff, with a degree of clarity that may have been missing to date.	11
	57. The Care Quality Commission should undertake a formal evaluation of how it would detect and take action on the warning signs and other events giving cause for concern at the Trust described in this report, and in the report of the first inquiry, and open that evaluation for public scrutiny.	11
	58. Patients, through their user group representatives, should be integrated into the structure of the Care Quality Commission. It should consider whether there is a place for a patients' consultative council with which issues could be discussed to obtain a patient perspective directly.	11
	59. Consideration should be given to the introduction of a category of nominated board members from representatives of the professions, for example, the Academy of Medical Royal Colleges, a representative of nursing and allied healthcare professionals, and patient representative groups.	11/10
	62. For as long as it retains responsibility for the regulation of foundation trusts, Monitor should	

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	incorporate greater patient and public involvement into its own structures, to ensure this focus is always at the forefront of its work.	
	63. Monitor should publish all side letters and any rating issued to trusts as part of their authorisation or licence.	10
	65. The NHS Trust Development Authority should develop a clear policy requiring proof of fitness for purpose in delivering the appropriate quality of care as a pre-condition to consideration for support for a foundation trust application.	4
	66. The Department of health, the NHS Trust Development Authority and Monitor should jointly review the stakeholder consultation process with a view to ensuring that: • Local stakeholder and public opinion is sought on the fitness of a potential applicant NHS trust for foundation trust status and in particular on whether a potential applicant is delivering a sustainable service compliant with fundamental standards; • An accessible record of responses received is maintained; • The responses are made available for analysis on behalf of the Secretary of State, and, where an application is assessed by it, Monitor.	4
	67. The NHS Trust Development Authority should develop a rigorous process for the assessment as well as the support of potential applicants for foundation trust status. The assessment must include as a priority focus a review of the standard of service delivered to patients, and the sustainability of a service at the required standard.	4
	69. The assessment criteria for authorisation should include a requirement that applicants demonstrate their ability to consistently meet fundamental patient safety and quality standards at the same time as complying with the financial and corporate governance requirements of a foundation trust.	4
	70. A duty of utmost good faith should be imposed on applicants for foundation trust status to disclose to the regulator any significant information material to the application and to ensure that any information is complete and accurate. This duty should continue throughout the application process, and thereafter in relation to the monitoring of compliance.	4
	71. The Secretary of State's support for an application should not be given unless he is satisfied	

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	that the proposed applicant provides a service to patients which is, at the time of his consideration, safe, effective and compliant with all relevant standards, and that in his opinion it is reasonable to conclude that the proposed applicant will continue to be able to do so for the foreseeable future. In deciding whether he can be so satisfied, the Secretary of State should have regard to the required public consultation and should consult with the healthcare regulator.	4
	72. The assessment for an authorisation of applicant for foundation trust status should include a full physical inspection of its primary clinical areas as well as all wards to determine whether it is compliant with fundamental safety and quality standards.	10
	73. The Department of Health's regular performance reviews of Monitor (and the Care Quality Commission) should include an examination of its relationship with the Department of Health and whether the appropriate degree of clarity of understanding of the scope of their respective responsibilities has been maintained.	10
	74. Monitor and the Care Quality Commission should publish guidance for governors suggesting principles they expect them to follow in recognising their obligation to account to the public, and in particular in arranging for communication with the public served by the foundation trust and to be informed of the public's views about the services offered.	10
	75. The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest. They should produce an agreed published description of the role of the governors and how it is planned that they perform it. Monitor and the Care Quality Commission should review these descriptions and promote what they regard as best practice.	10
	76. Arrangements must be made to ensure that governors are accountable not just to the immediate membership but to the public at large – it is important that regular and constructive contact between governors and the public is maintained.	10
	78. The Care Quality Commission and Monitor should consider how best to enable governors to have access to a similar advisory facility in relation to compliance with healthcare standards as will be available for compliance issues in relation to breach of a licence (pursuant to section 39A of the National Health Service Act 2006 as amended), or other ready access to external	

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	assistance.	
	79. There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.	10
	80. A finding that a person is not a fit and proper person on the grounds of serious misconduct or incompetence should be a circumstance added to the list of disqualifications in the standard terms of a foundation trust's constitution.	11
	81. Consideration should be given to including in the criteria for fitness a minimum level of experience and/or training, while giving appropriate latitude for recognition of equivalence.	11
	82. Provision should be made for regulatory intervention to require the removal or suspension from office after due process of a person whom the regulator is satisfied is not or is no longer a fit and proper person, regardless of whether the trust is in significant breach of its authorisation or licence.	10
	83. If a "fit and proper person test" is introduced as recommended, Monitor should issue guidance on the principles on which it would exercise its power to require the removal or suspension or disqualification of directors who did not fulfil it, and the procedure it would follow to ensure due process.	10
	84. Where the contract of employment or appointment of an executive or non-executive director is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit and proper person to hold such a post, licensed bodies should be obliged by the terms of their licence to report the matter to Monitor, the Care Quality Commission and the NHS Trust Development Authority.	10
	85. Monitor and the Care Quality Commission should produce guidance to NHS and foundation trusts on procedures to be followed in the event of an executive or non-executive director being found to have been guilty of serious failure in the performance of his or her office, and in particular with regard to the need to have regard to the public interest in protection of patients and maintenance of confidence in the NHS and the healthcare system.	10

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	86. A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors.	10
	87. The Health and Safety Executive is clearly not the right organisation to be focusing on healthcare. Either the Care Quality Commission should be given power to prosecute 1974 Act offences or a new offence containing comparable provisions should be created under which the Care Quality Commission has power to launch a prosecution.	13
	88. The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	13
	89. Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	13
	90. In order to determine whether a case is so serious, either in terms of the breach of safety requirements or the consequences for any victims, that the public interest requires individuals or organisations to be brought to account for their failings, the Health and Safety Executive should obtain expert advice, as is done in the field of healthcare litigation and fitness to practise proceedings.	15
	92. The financial incentives at levels below level 3 should be adjusted to maximise the motivation to reach level 3.	15
	93. The NHS Litigation Authority should introduce requirements with regard to observance of the guidance to be produced in relation to staffing levels, and require trusts to have regard to evidence-based guidance and benchmarks where these exist and to demonstrate that effective risk assessments take place when changes to the numbers or skills of staff are under consideration. It should also consider how more outcome based standards could be designed to enhance the prospect of exploring deficiencies in risk management, such as occurred at the Trust.	15
	94. As some form of running record of the evidence reviewed must be retained on each claim in	

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	order for these reports to be produced, the NHS Litigation Authority should consider development of a relatively simple database containing the same information.	
	95. As the interests of patient safety should prevail over the narrow litigation interest under which confidentiality or even privilege might be claimed over risk reports, consideration should also be given to allowing the Care Quality Commission access to these reports.	15
	96. The NHS Litigation Authority should make more prominent in its publicity an explanation comprehensible to the general public of the limitations of its standards assessments and of the reliance which can be placed on them.	15
	106. The Health Protection Agency and its successor, should coordinate the collection, analysis and publication of information on each provider's performance in relation to healthcare associated infections, working with the Health and Social Care Information Centre.	16
	107. If the Health Protection Agency or its successor, or the relevant local director of public health or equivalent official, becomes concerned that a provider's management of healthcare associated infections is or may be inadequate to provide sufficient protection of patients or public safety, they should immediately inform all responsible commissioners, including the relevant regional office of the NHS Commissioning Board, the Care Quality Commission and, where relevant, Monitor, of those concerns. Sharing of such information should not be regarded as an action of last resort. It should review its procedure to ensure clarity of responsibility for taking this action.	16
	108. Public Health England should review the support and training that health protection staff can offer to local authorities and other agencies in relation to local oversight of healthcare providers' infection control arrangements.	16
	111. Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.	3
	112. Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal	3

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	complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.	3
	115. Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply: • A complaint amounts to an allegation of a serious untoward incident; • Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion; • A complaint raises substantive issues of professional misconduct or the performance of senior managers; • A complaint involves issues about the nature and extent of the services commissioned.	3
	116. Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	3
	117. A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.	3
	119. Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to respect for patient confidentiality.	3
	120. Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so.	3
	121. The Care Quality Commission should have a means of ready access to information about the most serious complaints. Their local inspectors should be charged with informing themselves of such complaints and the detail underlying them.	3
	145. There should be a consistent basic structure for Local Healthwatch throughout the country, in accordance with the principles set out in *Chapter 6: Patient and public local involvement and*	

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	scrutiny.	
	146. Local authorities should be required to pass over the centrally provided funds allocated to its Local Healthwatch, while requiring the latter to account to it for its stewardship of the money. Transparent respect for the independence of Local Healthwatch should not be allowed to inhibit a responsible local authority – or Healthwatch England as appropriate – intervening.	6
	148. The complexities of the health service are such that proper training must be available to the leadership of Local Healthwatch as well as, when the occasion arises, expert advice.	6
	149. Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.	6
	150. Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action.	6
	151. MPs are advised to consider adopting some simple system for identifying trends in the complaints and information they received from constituents. They should also consider whether individual complaints imply concerns of wider significance than the impact on one individual patient.	18
	154. The Care Quality Commission and Monitor should develop practices and procedures with training regulators and bodies responsible for the commissioning and oversight of medical training to coordinate their oversight of healthcare organisations which provide regulated training.	18
	155. The General Medical Council should set out a standard requirement for routine visits to each local education provider, and programme in accordance with the following principles: • The Postgraduate Dean should be responsible for managing the process at the level of the Local Educational Training Board, as part of overall deanery functions. • The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required. • There should be lay or patient representation on visits to ensure that patient interests are	

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	maintained as the priority. • Such visits should be informed by all other sources of information and, if relevant, coordinated with the work of the Care Quality Commission and other forms of review. The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out. All healthcare organisations must be required to release healthcare professionals to support the visits programme. It should also be recognised that the benefits in professional development and dissemination of good practice are of significant value. **156.** The system for approving and accrediting training placement providers and programmes should be configured to apply the principles set out above. **157.** The General Medical Council should set out a clear statement of what matters; deaneries are required to report to the General Medical Council either routinely or as they arise. Reports should include a description of all relevant activity and findings and not be limited to exceptional matters of perceived non-compliance with standards. Without a compelling and recorded reason, no professional in a training organisation interviewed by a regulator in the course of an investigation should be bound by a requirement of confidentiality not to report the existence of an investigation, and the concerns raised by or to the investigation with his own organisation. **158.** The General Medical Council should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients. **159.** Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provided to patients. The General Medical Council should consult the Care Quality Commission in developing the survey and routinely share information obtained with healthcare regulators. **160.** Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.	18 18 18 18 18 18

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	161. Training visits should make an important contribution to the protection of patients: • Obtaining information directly from trainees should remain a valuable source of information – but it should not be the only method used. • Visits to, and observation of, the actual training environment would enable visitors to detect poor practice from which both patients and trainees should be sheltered. • The opportunity can be taken to share and disseminate good practice with trainers and management. Visits of this nature will encourage the transparency that is so vital to the preservation of minimum standards.	18
	162. The General Medical Council should in the course of its review of its standards and regulatory process ensure that the system of medical training and education maintains as its first priority the safety of patients. It should also ensure that providers of clinical placements are unable to take on students or trainees in areas which do not comply with fundamental patient safety and quality standards. Regulators and deaneries should exercise their own independent judgement as to whether such standards have been achieved and if at any stage concerns relating to patient safety are raised to the, must take appropriate action to ensure these concerns are properly addressed.	18
	163. The General Medical Council's system of reviewing the acceptability of the provision of training by healthcare providers must include a review of the sufficiency of the numbers and skills of available staff for the provision of training and to ensure patient safety in the course of training.	18
	164. The Department of Health and the General Medical Council should review whether the resources available for regulating Approved Practice Setting are adequate and, if not, make arrangements for the provision of the same. Consideration should be given to empowering the General Medical Council to charge organisations a fee for approval.	18
	165. The General Medical Council should immediately review its approved practice settings criteria with a view to recognition of the priority to be given to protecting patients and the public.	18
	166. The General Medical Council should in consultation with patient interest groups and the public immediately review its procedures for assuring compliance with its approved practice	

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	settings criteria with a view in particular to provision for active exchange of relevant information with the healthcare systems regulator, coordination of monitoring processes with others required for medical education and training, and receipt of relevant information from registered practitioners of their current experience in approved practice settings approved establishments.	18
	167. The Department of Health and the General Medical Council should review the powers available to the General Medical Council in support of assessment and monitoring of approved practice settings establishments with a view to ensuring that the General Medical Council (or if considered to be more appropriate, the healthcare systems regulator) has the power to inspect establishments, either itself or by an appointed entity on its behalf, and to require the production of relevant information.	18
	168. The Department of Health and the General Medical Council should consider making the necessary statutory (and regulatory changes) to incorporate the approved practice settings scheme into the regulatory framework for postgraduate training.	18
	170. Health Education England should have a medically qualified director of medical education and a lay patient representative on its board.	18
	171. All Local Education and Training Boards should have a post of medically qualified postgraduate dean responsible for all aspects of postgraduate medical education.	18
	172. The Government should consider urgently the introduction of a common requirement of proficiency in communication in the English language with patients and other persons providing healthcare to the standard required for a registered medical practitioner to assume professional responsibility for medical treatment of an English-speaking patient.	22
	174. Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	22
	175. Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal	

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	representative).	22
	176. Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.	22
	181. A statutory obligation should be imposed to observe a duty of candour: • On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request; • On registered medical practitioners and registered nurses and other registered professionals who believe or • suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable. The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.	22
	183. It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation: • Knowingly to obstruct another in the performance of these statutory duties; • To provide information to a patient or nearest relative intending to mislead them about such an incident; • Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties.	22
	184. Observance of the duty should be policed by the Care Quality Commission, which should have powers in the last resort to prosecute in cases of serial non-compliance or serious and wilful deception. The Care Quality Commission should be supported by monitoring undertaken by commissioners and others.	23
	187. There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision	

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	of a registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care. Satisfactory completion of this direct care experience should be a pre-condition to continuation in nurse training. Supervised work of this type as a healthcare support worker should be allowed to count as an equivalent. An alternative would be to require candidates for qualification for registration to undertake a minimum period of work in an approved healthcare support worker post involving the delivery of such care.	23
	192. The Department of Health and Nursing and Midwifery Council should introduce the concept of a Responsible Officer for nursing, appointed by the accountable to, the Nursing and Midwifery Council.	23
	193. Without introducing a revalidation scheme immediately, the Nursing and Midwifery Council should introduce common minimum standards for appraisal and support with which responsible officers would be obliged to comply. They could be required to report to the Nursing and Midwifery Council on their performance on a regular basis.	23
	194. As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio and up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if required, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.	23
	195. Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision of the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives, Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance e and deliver training and/or feedback as appropriate, including a	

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	robust annual appraisal.	23
	199. Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, wherever possible, be present at every interaction between a doctor and an allocated patient.	23
	201. The Royal College of Nursing should consider whether it should formally divide its "Royal College" functions and its employee representative/trade union functions between two bodies rather than behind internal "Chinese walls".	23
	202. Recognition of the importance of nursing representation at provider level should be given by ensuring that adequate time is allowed for staff to undertake this role, and employers and unions must regularly review the adequacy of the arrangements in this regard.	23
	213. Until such time as the Nursing and Midwifery Council is charged with the recommended regulatory responsibilities, the Department of Health should institute a nationwide system to protect patients and care receivers from harm. This system should be supported by fair due process in relation to employees in this grade who have been dismissed by employers on the grounds of a serious breach of the code of conduct or otherwise being unfit for such a post.	12
	222. The General Medical Council should have a clear policy about the circumstances in which a generic compliant or report to be made to it, enabling a more proactive approach to monitoring fitness to practice.	12
	223. If the General Medical Council is to be effective in looking into generic complaints and information it will probably need either greater resources, or better cooperation with the Care Quality Commission and other organisations such as the Royal Colleges to ensure that it is provided with the appropriate information.	12
	224. Steps must be taken to systematise the exchange of information between the Royal Colleges and the General Medical Council, and to issue guidance for use by employers of doctors to the same effect.	12
	225. The General Medical Council should have regard to the possibility of commissioning peer	

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	reviews pursuant to section 35 of the Medical Act 1983 where concerns are raised in a generic way, in order to be advised whether there are individual concerns. Such reviews could be jointly commissioned with the Care Quality Commission in appropriate cases.	12
	226. To act as an effective regulator of nurse managers and leaders, as well as more front-line nurses, the Nursing and Midwifery Council needs to be equipped to look at systemic concerns as well as individual ones. It must be enabled to work closely with the systems regulators and to share their information and analyses on the working of systems in organisations in which nurses are active. It should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures. Full access to the Care Quality Commission information in particular is vital.	12
	227. The Nursing and Midwifery Council needs to have its own internal capacity to assess systems and launch its own proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues. It may decide to seek the cooperation of the Care Quality Commission, but as an independent regulator it must be empowered to act on its own if it considers it necessary in the public interest. This will require resources in terms of appropriately expert staff, data systems and finance. Given the power of the registrar to refer cases without a formal third party complaint, it would not appear that a change of regulation is necessary, but this should be reviewed.	12
	228. It is of concern that the administration of the Nursing and Midwifery Council, which has not been examined by this Inquiry, is still found by other reviews to be wanting. It is imperative in the public interest that this is remedied urgently. Without doing so, there is a danger that the regulatory gap between the Nursing and Midwifery Council and the Care Quality Commission will widen rather than narrow.	12
	229. It is highly desirable that the Nursing and Midwifery Council introduces a system of revalidation similar to that of the General Medical Council, as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. It is essential that the Nursing and Midwifery Council has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.	12
	230. The profile of the Nursing and Midwifery Council needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients	

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	should be informed, by those providing treatment or care, of the existence and role of the Nursing and Midwifery Council, together with contact details. The Nursing and Midwifery Council itself needs to undertake more by way of public promotion of its functions.	12
	231. It is essential that, so far as practicable, Nursing and Midwifery Council procedures do not obstruct the progress of internal disciplinary action in providers. In most cases it should be possible, through cooperation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures, to make it clear that the employer is entitled to proceed even if there are pending Nursing and Midwifery Council proceedings.	12
	232. The Nursing and Midwifery Council could consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing. If this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap.	12
	233. While both the General Medical Council and the Nursing and Midwifery Council have highly informative internet sites, both need to ensure that patients and other service users are made aware at the point of service provision of their existence, their role and their contact details.	12
	234. Both the General Medical Council and Nursing and Midwifery Council must develop closer working relationships with the Care Quality Commission – in many cases there should be joint working to minimise the time taken to resolve issues and maximise the protection afforded to the public.	12
	235. The Professional Standards Authority for Health and Social Care (PSA) (formerly the Council for Healthcare Regulatory Excellence), together with the regulators under its supervision, should seek to devise procedures for dealing consistently and in the public interest with cases arising out of the same event or series of events but involving professionals regulated by more than one body. While it would require new regulations, consideration should be given to the possibility of moving towards a common independent tribunal to determine fitness to practise issues and sanctions across the healthcare professional field.	25
	236. Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	25

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	237. There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	25
	238. Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: • All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors. • Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. • The NHS should develop a greater willingness to communicate by email with relatives. • The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. • Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.	25
	239. The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	25
	240. All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior of these.	25
	241. The arrangements and best practice for providing food and drink to elderly patients requires constant review, monitoring and implementation.	25
	242. In the absence of automatic checking and prompting, the process of the administration of medicine needs to be overseen by the nurse in charge of the ward, or his/her delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one	

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	ward to another, or they are returned to the ward after treatment.	25
	243. The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and names nurses are responsible for ensuring that the observations are carried out and recorded.	26
	245. Each provider organisation should have a board level member with responsibility for information.	26
	248. Healthcare providers should be required to have their quality accounts independently audited. Auditors should be a given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts.	26
	249. Each quality account should be accompanied by a declaration signed by all directors in office at the date of the account certifying that they believe the contents of the account to be true, or alternatively a statement of explanation as to the reason any such director is unable or has refused to sign such a declaration.	26
	250. It should be a criminal offence for a director to sign a declaration of belief that the contents of a quality account are true if it contains a misstatement of fact concerning an item of prescribed information which he/she does not have reason to believe is true at the time of making the declaration.	26
	251. The Care Quality Commission and/or Monitor should keep the accuracy, fairness and balance of quality accounts under review and should be enabled to require corrections to be issued where appropriate. In the event of an organisation failing to take that action, the regulator should be able to issue its own statement of correction.	26
	255. Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near “real time” as possible, even if later adjustments have to be made.	26
	256. A proactive system for following up patients shortly after discharge would not only be good	

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	"customer service", it would probably provide a wider range of responses and feedback on their care.	26
	258. The Information Centre should continue to develop and maintain learning, standards and consensus with regard to information methodologies, with particular reference to comparative performance statistics.	26
	262. All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: • Effective real-time information on the performance of each of their services against patient safety and minimum quality standards; • Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations such as the medical Royal Colleges. The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment.	26
	268. Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry.	26
	269. The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved.	26
	272. There is a demonstrable need for an accreditation system to be available for healthcare-relevant statistical methodologies. The power to create an accreditation scheme has been included in the Health and Social Care Act 2012, it should be used as soon as practicable.	14/22
	273. The terms of authorisation, licensing and registration and any relevant guidance should oblige healthcare providers to provide all relevant information to enable the coroner to perform	

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	his function, unless a director is personally satisfied that withholding the information is justified in the public interest.	2
	274. There is an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest.	14
	275. It is of considerable importance that independent medical examiners are independent of the organisation whose patients' deaths are being scrutinised.	14
	276. Sufficient numbers of independent medical examiners need to be appointed and resourced to ensure that they can give proper attention to the workload.	14
	277. National guidance should set out standard methodologies for approaching the certification of the cause of death to ensure, so far as possible, that similar approaches are universal.	14
	278. It should be a routine part of an independent medical examiners' role to seek out and consider any serious untoward incidents or adverse incident reports relating to the deceased, to ensure that all circumstances are taken into account whether or not referred to in the medical records.	14
	279. So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment.	14
	280. Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.	14
	281. It is important that independent medical examiners and any others having to approach families for this purpose have careful training in how to undertake this sensitive task in a manner least likely to cause additional and unnecessary distress.	14
	282. Coroners should send copies of relevant Rule 43 reports to the CQC.	14

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	283. Guidance should be developed for coroners' offices about whom to approach in gathering information about whether to hold an inquest into the death of a patient. This should include contact with the patient's family.	14
	284. The Lord Chancellor should issue guidance as to the criteria to be adopted in the appointment of assistant deputy coroners.	14
	285. The Chief Coroner should issue guidance on how to avoid the appearance of bias when assistant deputy coroners are associated with a party in a case.	19
	289. Department of Health officials need to connect more to the NHS by visits, and most importantly by personal contact with those who have suffered poor experiences. The Department of Health could also be assisted in its work by involving patient/service user representatives through some form of consultative forum within the Department.	19
	290. Department of Health should promote a shared positive culture by setting an example in its statements by being open about deficiencies, ensuring those harmed have a remedy, and making information publicly available about performance at the most detailed level.	