

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

NHS Confederation summary and response

1. Introduction
 2. NHS Confederation viewpoint
 3. Summary of the recommendations
-

1. Introduction

Introduction

The final report of the public inquiry into Mid Staffordshire NHS Foundation Trust provides detailed and systematic analysis of what contributed to the failings in care at the trust. It identifies how the extensive regulatory and oversight infrastructure failed to detect and act effectively to address the trust's problems for so long, even when the extent of the problems were known.

The report builds on the first independent inquiry, also chaired by Robert Francis QC. Its three volumes and an executive summary run to 1,782 pages, and is structured around:

- warning signs that existed and could have revealed the issues earlier
- governance and culture
- roles of different organisations and agencies
- present and future.

It recognises that what happened in Mid Staffs was a system failure, as well as a failure of the organisation itself. Rather than proposing a significant reorganisation of the system, the report concludes that a fundamental change in culture is required to prevent this system failure from happening again, and that many of the changes can be implemented within the current system. It stresses the importance of avoiding a blame culture, and proposes that the NHS – collectively and individually – adopt a learning culture aligned first and foremost with the needs and care of patients.

The report makes 290 recommendations, which focus primarily on securing a greater cohesion and culture across the system, which 'will not be brought about by further "top down" pronouncements, but by the engagement of every single person serving patients'. However, no single recommendation should be regarded as the solution to the many concerns identified.

This briefing summarises the main recommendations and NHS Confederation's initial analysis of the inquiry's report. More detailed analysis and comment will follow, which will build on a systematic programme of member engagement over the coming months.

2. NHS Confederation viewpoint

Patients must always come first if the NHS is to deliver the best and safest care possible.

Our members believe that patient care is everyone's responsibility. This is why implementing some of the recommendations in this report will be difficult, but the right thing to do.

It's also why we will want to take more time to consider some of Francis' recommendations, so they achieve the desired effect without acting as a sticking plaster for better care.

While the inquiry was confined to Mid Staffs, there is evidence there are other places where unhealthy cultures, poor leadership and an acceptance of poor standards are too prevalent. Robert Francis' first recommendation is for everyone in the NHS to urgently consider and review what happens in their own organisation in light of the inquiry's findings, and identify any actions they may need to take to ensure what happened in Stafford does not happen in their organisation.

This work must form part of a solution to the problem – a key part of which will be harnessing the good work of the majority of hospitals and spreading that best practice across the country.

Indeed, we agree that the report's stated desire for more transparency, and real-time information for both the public and providers will ensure the spread of accountability at all levels of the NHS. In addition, by providing clarity over who is responsible for improvements in quality we have, for the first time ever, a real mandate for change.

We think that Robert Francis was entirely right to shine a spotlight on the current complaints system, where many patients feel frustrated and ignored. However, we believe this work must go hand in hand with a focus on the ways in which we can prevent complaints occurring in the first place.

More broadly, we concur with Robert Francis' view that the whole system must now revolve around quality and that top-down management is no longer viable. We are also clear that the levers for the transformation of services are already embedded in the system.

There has been a great deal of discussion about whether managers should be regulated and suggestions for strengthening the accountability of NHS managers – we would welcome that, if done in a way that adds benefit, not just bureaucracy. But equally, steps to attract, reward and keep good NHS leaders would have a positive impact on patients.

We echo Francis' desire not to lay the blame at any individual's door - and we are clear that Mid-Staffs was a reflection of a system-wide failure.

Finally, it is important to say those that provide good care, those who oversee well-run and safe hospitals, have nothing to fear from the Francis report. It is also clear these good hospitals will step up to the mark when it comes to finding solutions for those struggling to deliver.

We will be working with our members over the coming weeks and months to look at the proposals in more detail, below we have highlighted some specific areas we will be looking at as an example:

Delivering compassionate care

We are pleased to see our *Delivering Dignity* report referenced in the report and that many of the recommendations suggested by Robert Francis are consistent with what we have been asking for, including: putting patients first, listening to and acting on their feedback, embracing a devolved style of leadership and recruiting people with compassionate values. We remain committed to working with our members, in partnership with Age UK and the Local Government Association, to make these recommendations a reality.

Closer alignment of Monitor and CQC

The way that quality and finance is regulated in the NHS is important for preventing failure from occurring. We have raised a number of concerns about the lack of alignment between

the Care Quality Commission and Monitor in the new system for the NHS and over the coming weeks, we will work with our members to analyse the proposals put forward by Robert Francis. It is essential for the regulatory system to understand the link between quality and financial failure and it needs to have the capacity to act collectively when warning signs of either become apparent.

Clarity of standards of quality

It is important there is clarity and consistency about standards of quality, with clear understanding of responsibilities. This includes clarity of roles across providers, commissioners and the regulators. It is good that the recommendations suggested by Francis would give greater clarity around standards of quality and responsibilities, from fundamental standards through to enhanced and discretionary standards. We will work with our members to look more closely at the proposals and what they might mean in practice.

Aligning the whole system

Better alignment of the whole system around quality objectives is essential, including the positive and open culture required to deliver them, and appropriate incentives and rewards. This also requires challenging the blame culture that often characterises the NHS at all levels, including regulatory systems. This approach dissuades honest conversations about the challenges and risks facing organisations, particularly in an increasingly competitive NHS. It also increases the likelihood that no one will want to take on the management or leadership of a struggling NHS organisation, particularly if the causes of problems are outside their control. We are committed to working with our members to achieve this.

3. Summary of the recommendations

Ensuring implementation of the inquiry's recommendations

At the heart of the report is a determination that the inquiry's recommendations and findings be implemented and not suffer the same fate as many previous inquiries. Its first recommendation sets out requirements for oversight and accountability to ensure implementation of its proposals, including:

- All commissioning, service provision, regulatory and ancillary organisations in healthcare should reflect on the report and its recommendations and decide how to apply them to their own work.
- Each organisation should announce at the earliest opportunity its decision on the extent to which it accepts the recommendations and what it intends to do to implement them.
- Each organisation should publish, at least annually, a report on its progress in achieving its planned actions.
- The Department of Health should publish a report, at least annually, collating information about the decisions, actions and progress reported by other organisations.
- The House of Commons Select Committee on Health should incorporate progress on implementation as part of their reviews of organisations in their normal business.

Creating the right culture and putting the patient first

The report highlights the importance of establishing a shared positive safety culture that permeates all levels of the healthcare system, which aspires to prevent harm to patients and provide where possible, excellent care and a common culture of caring, commitment and compassion. This requires:

- shared values in which the patient is the priority of everything done
- zero-tolerance of substandard care
- empowering frontline staff with the responsibility and freedom to deliver safe care

- strong and stable cultural leadership and organisational stability
- comparable data on outcomes
- expectations of openness, candour and honesty.

Leaders of organisations are expected to adopt the shared culture themselves, and be seen to do so. This should be supported by measures such as open board meetings, personally listening to complaints, and an open and honest admission where there is an inability to offer a service. At a system level, this should be demonstrated by constantly considering how the wellbeing of patients is protected or improved by proposed measures.

As the NHS evolves into a network of increasingly autonomous units, the overall culture will define what the NHS means and does. However, a positive culture will not emerge through the good intentions of those working in the system. It needs to be defined, accepted by those who are to be part of it, and continually reinforced by leadership, training, personal engagement and commitment. This will be the principal means to ensure uniformity of the standard of care and treatment.

The inquiry recommends that the NHS, and all who work for it, 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
- a tool or methodology, such as a cultural barometer, to measure the cultural health of all parts of the system.

Putting the patient first

The report underlines the importance of making patients the main priority in all that the healthcare system does. Within available resources, patients must be expected to receive effective services from caring, compassionate and committed staff, working to a common culture. They must also be protected from avoidable harm and any deprivation of their basic rights. Recommendations to achieve this are:

- Clarity of values and principles underpinning NHS care with the NHS Constitution being the first reference point for all NHS patients and staff, setting out:
 - the system's common values, and the respective rights, legitimate expectations and obligations of patients
 - clearly ensuring that patients are put first.
- Consideration should be given to include expectations in the NHS Constitution that staff:
 - put patients before themselves
 - do everything in their power to protect patients from avoidable harm
 - will be open and honest with patients, regardless of the consequences for themselves
 - direct patients to someone that can provide assistance with their needs if they are unable to
 - apply the NHS values in all their work.
- Revision of the handbook to the Constitution to include a more prominent reference to the NHS values and their significance.
- A requirement that all NHS staff enter into a commitment to abide by the NHS values and the Constitution, which should be incorporated into employment contracts.
- Contractors of outsourced services should also be required to abide by these requirements –these requirements could be included in the terms on which providers are commissioned.

Fundamental standards of behaviour

The report proposes that fundamental standards of behaviour, which apply to all staff that work and serve in the healthcare system, be enshrined in the NHS Constitution.

Recommendations to achieve this include:

- Incorporating explicit reference in the Constitution to all professional and managerial codes by which NHS staff are bound, and an expectation that staff will follow and comply with standards relevant to their work.
- Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work.
- Professional bodies should work to provide evidence-based standard procedures for as many interventions and pathways as possible.
- 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.
- Employers must insist on the reporting of concerns relating to patient safety – employees should receive feedback on any action taken.

An integrated hierarchy of standards of service

The report proposes establishing an integrated hierarchy of service standards to promote the likelihood that a service will be delivered safely and effectively. Standards would range from mandatory fundamental service standards to discretionary developmental standards, with clear expectation of zero-tolerance towards any organisation providing services that do not comply the fundamental standards. The standards should be evidence-based and measurable, and be clear about what needs to be done to comply. They should also be subject to regular review and modification. Recommendations include:

- Distinguishing between different types of standards to clarify their status and purpose.
 - Fundamental safety and care standards covered by regulation – these should:
 - set out clearly what is expected of providers, covering what is important for patients and advice on best practice for each area
 - clearly define universally agreed outcomes for patients that must be avoided
 - provide strong and practical guidance on what can be done and how it can be achieved and measured
 - include defined duties to maintain and operate effective systems to ensure compliance
 - be applied by all those working in the healthcare system with ‘zero tolerance of breaches’.
 - Individual cases of non-compliance leading to serious harm or death should remain as offences for which prosecutions can be brought against organisations.
 - Enhanced quality standards designed to drive improvements in services, which would be devised and performance managed by the NHS Commissioning Board and clinical commissioning groups (CCGs) and take account of the availability of resources.
 - Discretionary developmental standards formulated by commissioners and providers, which would set longer term goals for providers to improve effectiveness.
- Including generic requirements for a governance system in regulations, bringing together all the required elements of governance into one comprehensive standard to ensure compliance with the fundamental standards, and the provision and publication of accurate information about compliance with fundamental and enhanced standards.

Changes to fundamental standards will require new regulations, but these should be developed with extensive consultation, with patients, the public and healthcare professionals to ensure that they all have confidence in them.

Responsibility for, and effectiveness of, healthcare standards

The report highlights the importance of simplifying the regulation regime for NHS trusts to eradicate overlap and minimise the gaps between the functions of the different regulators. It proposes significant changes to the current division of regulatory responsibilities between Monitor and the Care Quality Commission (CQC), with the creation of a single regulator for all trusts, including foundation trusts. Monitor would retain its residual role as a regulator of the health economy. It suggests that these changes be implemented incrementally after thorough planning, and should not be used to justify reducing resources allocated to regulatory activity. It also stresses the importance of retaining the corporate memory of both organisations. Recommendations cover:

Creating a single regulator for all trusts

It is proposed that Monitor focuses on regulating the health economy, with the regulation of foundation trusts' governance passing to a single regulator, the CQC. This aims to produce a common approach and accountability, dealing with:

- corporate governance
- financial competence and viability
- compliance with patient safety and quality standards for all trusts.

Monitoring compliance with standards

- As the quality regulator, the CQC would be responsible for policing compliance with the fundamental standards, developing its core outcomes and specifying the indicators and metrics it would use to monitor compliance with these standards.
- The CQC should only be responsible for policing the accuracy of information provided about compliance with enhanced or developmental standards.
- The regulator should have a duty to monitor the accuracy of information from providers and commissioners on their compliance with standards and requirements of honest disclosure. The regulator should be able to consider individual cases of gross failure as well as systemic causes for concern.

Setting standards and developing evidence-based compliance

- Where possible, the National Institute for Health and Clinical Excellence (NICE) should provide the evidence-base for procedures and practices to support compliance with the fundamental standards. NICE Quality Standards for individual procedures and areas of treatment should be extended as soon as possible. These standards identify the minimum acceptable level of precaution to be taken, which is sufficient for the purposes of regulation.
- In absence of NICE Quality Standards, the Royal Colleges or other approved, third party organisations could be commissioned to develop relevant procedures, metrics or guidance.
- A recognised system of review for these standards should be introduced, managed and supervised by NICE.
- Any standards should include evidence-based tools for establishing the **staffing needs** of each service, in terms of staff numbers and skill mix, although it is recognised that guidance would need to be flexible and give due regard to the need of different specialities and limitations on resources.

Effective assessment of compliance with standards

- Direct observations of the delivery of care and audit of records should take priority over monitoring and auditing protocols and policies.
- The CQC should retain an emphasis on inspection as a central method of monitoring compliance. This should be supported by establishing a specialist inspectorate for hospitals. The inspectorate should lead inspections of NHS hospital care, supported by teams including service users, clinicians and any other specialisms. Consideration should also be given to applying the same principle to the independent sector.

- The CQC should consider whether inspections could be conducted in collaboration with other agencies, or whether they can take advantage of any peer review arrangements available.
No system of information gathering and analysis is perfect or sufficient, therefore routine monitoring is essential.
- The regulatory system should retain capacity to undertake in-depth investigations where these appear to be required.
- Regulators should work together to share intelligence more readily to identify potential concerns earlier, and work should be undertaken to develop an agreed template for the sort of information each organisation would find useful.
- In assessing compliance, better use should be made of patient information and feedback, including complaints, and the CQC should actively seek out information on complaints.
- The CQC should introduce mandated returns from providers about complaints, how they were dealt with and outcomes. This should include greater attention being paid to the narrative in the complaints as well as numbers.
- CQC Quality and Risk Profiles should not be regarded as a substitute for active regulatory oversight by inspectors of the compliance in each provider.

Effective assessment of compliance and enforcement of compliance with standards

- Any service that does not consistently meet the relevant fundamental standards should not be allowed to continue.
- Effective enforcement should be ensured by installing a low threshold for suspicion, and no tolerance of non-compliance with fundamental standards.
- It should be a criminal offence where death or serious injury is caused by breaching fundamental standards.
- Failure to disclose breaches of fundamental standards should also attract regulatory actions.
- Interim measures:
 - The CQC should be able to take immediate steps to protect patients where it has reasonable cause for concern about an issue, even if it is still investigating non-compliance.
 - A public interest test should decide whether there are reasonable grounds to make the interim requirement or recommendation.

CQC independence, strategy and culture

- Any attempts to abolish the CQC and create a new organisation should be avoided, and its role should develop on an evolutionary basis.
- The CQC needs to be seen as acting entirely independently of government, and the Government should only consider it necessary to intervene in the CQC in the most extreme circumstances.
- The relationship between the CQC and the Department of Health (DH) must be meticulously transparent and where issues relating to regulatory action are discussed, they must be properly recorded to allay any suggestion of inappropriate interference.
- Transferring power to define standards to NICE, or a similar body, may protect the regulator's autonomy while retaining powers for the Secretary of State to define outcomes.
- The structure under which the CQC is required to work is over-bureaucratic and does not separate clearly what is absolutely essential from what is merely desirable.
- The strategic direction of the new regulatory model being developed by the CQC is encouraging, but the leadership of the CQC should communicate this clearly to the public and its staff.
- CQC should review its processes to ensure that it is capable of delivering effective regulatory oversight and enforcement in accordance with the principles set out in the inquiry's report.

- The CQC should undertake a formal evaluation of how it would detect and act on the warning signs or other events causing concern similar to events that occurred at Mid Staffs, and open that evaluation to public scrutiny. .
- The culture within the CQC needs to change – there is a pattern consistent with a negative and closed culture of the sort they should be combating; it must be a model of openness, so that it can encourage employees in regulated organisations to come forward with concerns.
- The CQC board should have closer involvement with the healthcare professional community and patient representative groups.

Responsibility for, and effectiveness of, regulating healthcare systems governance

Consolidating Monitor's regulatory functions

- As long as it retains responsibility for the regulation of foundation trusts (FTs), Monitor should incorporate greater patient and public involvement into its structures.
- Monitor must publish all side letters and any rating issued to trusts as part of their authorisation or licence.

Authorisation of FTs

- The processes of authorising FTs and monitoring compliance with FT standards should pass to the CQC, which should incorporate the relevant departments of Monitor
- The NHS Trust Development Authority (NTDA) must 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 FT application
- No NHS trust should be supported to apply for FT status unless it meets the criteria for authorisation, including compliance with fundamental standards and a full physical inspection of its primary clinical areas and all wards.
- The stakeholder consultation process for assessing potential applicant NHS trusts for FT status should be jointly reviewed by DH, NTDA and Monitor.
- There should be a duty on applicants for FT status of utmost good faith to disclose any significant material information to the application, alongside ongoing obligations of transparency, openness and honesty.

Role of FT governors

- The role of FT governors should be enhanced, and become more accountable.
- Monitor and post-merger CQC should publish guidance to clarify what is expected of governors. what the fit and proper person test means, and what steps an FT should take if a governor fails to fulfil requirements.
- Guidance should also cover the principles governors should follow to ensure effective public accountability, not just to immediate membership, but to the public at large
- Monitor and the NHS Commissioning Board should review the resources and facilities available for training and development of governors to enhance their independence and their ability to expose deficiencies in a provider's services.

Accountability of directors

- All directors of all bodies registered by the CQC and Monitor should be, and remain, a fit and proper person for the role.
- Consideration should be given to including as criteria for fitness a minimum level of expertise and/or training.
- Monitor and the CQC should produce guidance on procedures to be followed in the event of an executive or non-executive director being found guilty of serious failure in the performance of their office.
- FTs should be required to have in place an adequate programme for the training and development of directors.

Commissioning for standards

The section on commissioning for standards pulls out the reflections and lessons learned by the primary care trust. The report suggests commissioning as a practice must be refocused to procure the necessary standards of a service as well as what it provides as a service (outcomes in quality as well as activity). Below are the recommendations for future commissioners:

- Commissioners should be closer to the public. The engagement of the public needs to be visible in the commissioning process, at board level, through consultations, surveys and transparent decision making.
- Commissioners should set the commissioning agenda and make the final decision on what services are provided at a local level.
- Commissioners should be entitled to lay down a fundamental safety and quality standard/specification for services, as well as how the commissioner will measure compliance.
- In addition to fundamental standards, commissioners can promote improvement by requiring compliance with or development towards enhanced standards.
- Wherever possible, commissioners need to identify/make available alternative sources of provision so they are not constrained to one provider. To achieve this, commissioning may need to be undertaken collaboratively among commissioning groups to add collective weight to discussions with more dominant providers.
- Commissioners need specialist clinical expertise (not all of which can come from GPs), as well as procurement expertise to undertake their role effectively. Where commissioning groups are too small in themselves to acquire such support, they will need to collaborate with others.
- Commissioners must have the capacity and resources to monitor the performance of every commissioning contract on a continuing basis during the contract period, this may include:
 - quality information generated by the provider
 - commissioners undertaking their own (or independent) audits, inspections, and investigations
 - the possession of accurate, relevant, and useable information
 - monitoring compliance both with the fundamental standards and with any enhanced standards adopted.
- Commissioners must be entitled to intervene in the management of an individual complaint when they feel it is not dealt with satisfactorily (while the provider has primary responsibility). They must monitor complaints and their outcomes on as near a real time basis as possible.
- Commissioners should have contingency plans in place to mitigate risk from substandard or unsafe services.
- Commissioners should intervene where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from harm. These powers should align and compliment the role/action of regulators – acting jointly where needed. One method of action may be through the issuing of performance notices.
- 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.
- GPs in primary care should undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services, developing an ongoing relationship and recording this through a systematic shared process. This will enable them to be aware of patterns of concern at a population level and effectively influence commissioning decisions.

Performance management and strategic oversight

In relation to the work of the local Strategic Health Authority (SHA), Francis points to "a significant gap between the legislative and policy theory of the role...and their capacity to

carry this role out." For example, he highlights concerns around the prioritisation of "targets not patients" and "an over-ready acceptance of action plans" from the Mid Staffordshire board, without ensuring robust scrutiny was undertaken. The report's recommendations include:

- Ensuring fundamental patient safety and quality standards are being met and are the top priority for all NHS performance managers. It is essential that "convincing evidence" is provided before assurance is offered.
- All appropriate information should be shared "wherever possible" by performance managers with regulators in circumstances when concerns are highlighted.
- While any disagreements between performance managers and regulators around patient safety "should be discussed...and resolved where possible", Francis emphasises that each body "should recognise its retained individual responsibility" to act to alleviate any safety concerns.
- "Unambiguous lines of referral and information flows" are integral to ensure the performance manager "is not in ignorance of the reality."
- Francis advocates a clear set of quality and safety metrics that can be universally applied to support prompt identification of both outliers and trusts that are experiencing declining performance.
- The NHS Commissioning Board is tasked with developing quality and outcomes metrics for commissioners to utilise in performance managing providers.

Patient, public and local scrutiny

The report concludes that the standard of representation of patient and public concerns declined since the abolition of Community Health Councils (CHCs) in 2002. It suggests that Patient and Public Involvement Forums and local involvement networks (LINKs) failed to offer a route through which patients and members of the public could link into health services and hold them properly to account.

- The report recommends that there should be a consistent basic structure for Local Healthwatch throughout the country and local authorities should pass over centrally provided funds to Local Healthwatch, "requiring the latter to account to it for its stewardship of the money". Proper training should also be made available to Local Healthwatch leadership, as well as expert advice when needed.
- Local scrutiny committees should be given more support, such as accessible guidance and benchmarks. They should also have powers to inspect providers, rather than relying on local patient involvement structures to fulfil this role.
- Guidance should be issued, in order to promote the coordination and cooperation between Local Healthwatch, health and wellbeing boards and local government scrutiny committees.
- MPs are asked to consider adopting a simple system to identify trends in complaints and to consider if individual complaints have wider significance.

Effective complaints handling

The report recognises that there should be a uniform process for managing complaints and that the "recommendations and standards suggested in the Patients Association's peer review into complaints at the trust should be reviewed and implemented nationally".

- Provider organisations must actively promote their desire to learn and act on comments and complaints. They must make it easy for those who wish to do so using a number of different methods.
- Overview and scrutiny committees, Local Healthwatch, commissioners and the CQC should all have access to complaints information. Where necessary, complaints should be investigated through an arms length independent investigation or where there are large scale clinical failures, the response should be coordinated through the National Quality Board.

- Commissioners should require access to complaints information at the time the complaints are made and should receive complaints and their outcomes “on as near real-time basis as possible”

Openness, transparency and candour

The report concludes that "insufficient openness, transparency and candour lead to delays in victims learning the truth, obstruct the learning process, deter disclosure of information about concerns, and cause regulation and commissioning to be undertaken on inaccurate information and understanding." The overall recommendations include:

- Full disclosure 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 – whether or not the patient asks.
- All organisations should review their contracts of employment, policies and guidance to ensure they reflect the need for openness, transparency and candour, as well as the National Patient Safety Agency's (NPSA) *Being open* guidance. At a national level, this would include reviewing the NHS Constitution and amending the Code of Conduct for NHS Managers.
- Conditions of registration or authorisation of healthcare organisations should be amended
 - to include a standard requirement that any information provided to the public about services, compliance with statutory standards and statistical results is truthful and not misleading. Compliance with the standard should be regulated by the CQC.
 - to oblige healthcare providers to provide all relevant information to enable the coroner to perform his function, unless a director is personally satisfied that withholding the information is justified in the public interest.
- Healthcare organisations, regulators and commissioners should be banned from policies and contracts which seek, or appear to seek, to limit genuine public interest disclosure on patient safety and care ('gagging clauses').
- A statutory obligation should be imposed to observe a duty of candour on healthcare providers, registered medical practitioners, registered nurses and other registered professionals who believe or suspect that treatment or care provided has caused death or serious injury to a patient.
- An additional 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.
- 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 to:
 - knowingly to obstruct another in the performance of these statutory duties; provide information to a patient or nearest relative intending to mislead them about such an incident
 - dishonestly 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.
- The duty should be policed by the CQC, which should have powers to prosecute.

Nursing

The report recognises that, "much high-quality, committed and compassionate nursing is carried out day in and day out, often with inadequate recognition." However it states, "it is clear that the nursing issues found in Stafford are not confined to that hospital but are found throughout the country' and argues the NHS needs to give the highest priority to 'reversing the scandalous decline in standards." The report focuses on the culture of caring requiring more focus on delivering compassionate care at the point of recruitment, in training and through annual appraisal.

- The report cites *Delivering Dignity*, the report jointly produced by the NHS Confederation, Local Government Association and Age UK, which recommended staff be recruited for values and evaluated for compassion, as well as technical skills.
- Nurse education should be reviewed to ensure consistent standards. Prior to entry, pre-registration training students will be required to spend "at least three months working on the direct care of patients under the supervision of a registered nurse".
- The DH and Nursing and Midwifery Council (NMC) should appoint a responsible officer for nursing appointed by and accountable to the NMC.
- Effective support and professional development for nurses should be made the responsibility of professionally accountable responsible officers for Nursing, and, in due course, reinforced by a system of revalidation.
- Nurses should be required to have an up-to-date annual learning portfolio showing up-to-date knowledge of nursing and demonstrating care, commitment and compassion.
- Ward managers should act in a supervisory capacity as role models and with knowledge of the care plans of all patients.
- A robust methodology for understanding the culture of the ward should be used, such as the use of a cultural barometer.
- Every patient should have a named nurse.
- Consideration to be given to the status of a registered older person's nurse.

The leadership function of nurses

- The Royal College of Nursing should consider dividing its Royal College and employee representative/trade union functions.
- Nurses need to be given sufficient time to fulfil representative roles.
- A forum should be established for directors of nursing from NHS and independent organisations.
- At least one executive director who is a registered nurse on the board of all healthcare organisations and commissioning boards and consider recruiting nurses as non-executive directors.
- Boards to seek advice of their nurse director on all changes affecting staffing and service provision and document if the advice is accepted or rejected

Healthcare support workers

- The inquiry concludes that the balance of the evidence is strongly in favour of a compulsory registration scheme for healthcare support workers, and the imposition of common standards of training and a code of conduct. It recommends that the NMC be the regulator. Such a register should include a record of the reasons for any termination of employment as a healthcare support worker. The possibility of a wider system for excluding those unfit to hold such posts should be kept under review.
- Until the NMC is charged with the recommended regulatory responsibilities, the DH should institute a nationwide system to protect patients and care receivers from harm.
- Healthcare support workers will be clearly identified, including by uniform, as distinct from registered nurses.

Leadership

- The report focuses on the leadership and development of a staff college or training system to:
 - provide common professional training on leadership and management
 - promote healthcare leadership and management as a profession
 - administer an accreditation scheme
 - promote and research best leadership practice.
- A code of ethics to be produced and enforced by employers. Serious non-compliance will disqualify board directors and managers from holding such positions in the future.

- Regulation of managers is to be considered after reviewing the impact of a licensing provision for managers.
- Consideration to be given to regulatory oversight of the competence and compliance of appropriate standards by non foundation trust boards of similar rigour to foundation trusts.

Caring for older people

The report concludes that “the true measure of the NHS’s effectiveness in delivering hospital care can be found in how well the elderly are looked after” and makes the following recommendations:

- Hospitals should review whether to reintroduce identifying a senior clinician who is in charge of a patient’s case, to help ensure there is clarity over who is in overall charge of a patient’s care. Nominating a named nurse for each patient for each shift is also recommended to improve the coordination of care.
- Emphasis is placed on the importance of team working, including recognising and valuing the contribution of cleaners, maintenance staff and catering staff.
- Regular interaction between nurses and patients should be systematised through regular ward rounds:
 - All staff need to be enabled to have constructive and friendly interactions with patients
 - Where possible, wards should have areas where patients and relatives can meet in relative privacy and comfort
 - There should be a greater willingness to communicate by email with relatives
 - The current common practice of summary discharge letters followed up by more substantive ones should be reconsidered
 - Information about a patient’s condition, progress, care and discharge plans should be shared with that patient and where appropriate those close to them.
- The care offered by a hospital should not end “merely because the patient has surrendered a bed”, patients should never be discharged in the middle of the night or without assurance that a patient will receive the care they need when they arrive at a planned destination. Discharge areas in hospital need to provide continued care to the patient.
- All visitors and staff need to be reminded to comply with hygiene requirements, including junior staff being encouraged to remind anyone, including senior staff.
- Arrangements and best practice for providing food and drink require “constant review, monitoring and implementation”.
- In the absence of automatic checking and prompting, the nurse in charge of the ward, or their nominated delegate, needs to over see the administration of medication, underpinned by a frequent check.
- Where possible, recording of observations on the ward should be done automatically as they are taken, with results immediately accessible to all staff electronically in a form.

Information

The report is clear about the positive role that information can play, encompassing issues such as: highlighting inadequate performance; accountability; informing the public; and supporting patient choice. Francis advocates an integrated system with common information practices, while acknowledging that the Government’s information strategy “appears to contain most if not all” of his suggested elements.

- Any electronic patient information system should have the facility to collect performance management and audit data automatically; be designed in partnership between health professionals and patient groups; and have the capability to go “over and above nationally required minimum standards.”
- All providers should appoint a board member that holds responsibility for information.

- Quality accounts should outline information in a standardised format to enable comparison. They should be subject to independent audit and all directors should sign a declaration to verify the contents. The CQC and/or Monitor "should keep the accuracy, fairness and balance of quality accounts under review", they should also have the ability to place a requirement on providers to make corrections where necessary.
- Information utilised for quality and risk profiles should be publicly available "as far as is consistent with maintaining any legitimate confidentiality."
- A consistent approach nationwide for gathering patient and public feedback about NHS services.
- The Health and Social Care Information Centre should have an enhanced role, with proposed tasks including, for example: independent collection, analysis, publication and oversight" of health information; the transferral of information functions from the NPSA to the Centre.
- All providers should implement information systems that can offer real-time performance data on services, specialist teams and consultants. The information should be published "to the extent practicable" and made fully available to both commissioners and regulators.
- It is stressed that "all healthcare professionals" should acknowledge their duty "to collaborate in the provision of information required" for treatment effectiveness data. Such information should be published and regularly.
- The DH, Information Centre and UK Statistics Authority should undertake a review of patient outcome statistics. The first two should collaborate on ensuring that summary hospital-level mortality indicators (SHMIs) "or any successor hospital mortality figures" are "recognised as national or official statistics."

Medical training and education and professional regulation of fitness to practice

A brief summary of the workforce-related recommendations, including those relating to medical training and education and professional regulation of fitness to practice, can be found on the [NHS Employers website](#).

Enhancement of the role of supportive agencies

National Patient Safety Agency (NPSA)

- The resources of the NPSA need to be well protected and defined. The report recommends that considerations should be given to transferring the resource provided by the National Reporting and Learning system from the NHS Commissioning Board to a semi-independent system regulator.
- The CQC should be enabled to exploit the potential of the safety information obtained by the NPSA or its successor to assist it in identifying areas for focussing attention. There needs to be a better dialogue between the two organisation concerning how they can assist each other.

Health Protection Agency (HPA)

- The report concludes that more robust arrangements for sharing infection control concerns with regulators and performance managers are needed. It calls on the HPA and its successor to work with the Health and Social Care Information Centre to coordinate the collection, analysis and publication of provider data, relating to healthcare associated infections.
- Where HPA or its successor is concerned that a provider is not adequately managing healthcare associated infections to protect the public and patients, they should immediately inform commissioners, the CQC and, where relevant, Monitor of their concerns.

Coroners and inquests

- Terms of registration/authorisation should oblige healthcare providers to provide all relevant information to enable the coroner to perform his function.
- Urgent need for unequivocal guidance for 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.
- 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.
- 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 concerns with the independent medical examiner.

Department of Health leadership

The report argues that the DH lacks a sufficient unifying theme and direction with regard to patients' safety. It also says that the DH has struggled to get the balance right between "light touch" regulation and the need to protect service users from harm. The report recommends the DH should:

- Bring together regulators to work with professionals and the public in developing a framework for implementing the values and standards recommended in the report.
- Set an example by being open about deficiencies, ensuring those harmed receive remedy and that information about performance is easily available.
- Ensure there is senior clinical involvement in all policy decisions which may impact on patient safety and wellbeing.

In addition, the report argues that while the DH asserted the importance of quality of care and patient safety, it failed to recognise that the structural reorganisations have on occasion made such a focus very difficult in practice. The report recommends that:

- Impact and risk assessments should be made public, and debated publically, before a proposal for any major structural change to the healthcare system is accepted.

The report found that at times DH officials were too far removed from the reality of the service they oversee. The report recommends:

- DH officials connect more to the NHS by visits and by personal contact with those who have suffered poor experience.