HEALTH SCRUTINY PANEL
29 JANUARY 2014
IMPLICATIONS FOR HEALTH SCRUTINY OF THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY (FRANCIS INQUIRY)
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider the implications for health scrutiny of the Government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry.

2. Action required

2.1 The Committee is asked to determine if, in light of the Government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry, any changes to the operation or approach of the Health Scrutiny Panel are required.

3. Background information

3.1 The Mid Staffordshire NHS Foundation Trust Public Inquiry (known as the Francis Inquiry) examined the appalling care and serious failings at Stafford Hospital between 2005 and 2008. The number of excess deaths between 2005 and 2008 was estimated at 492 people. Examples of poor care included patients being left in soiled bedclothes for lengthy periods, lack of assistance with eating and drinking, filthy wards and toilets, lack of privacy and dignity. The report described the failings as a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'. The Inquiry looked at the hospital and the roles of the main organisations with an oversight role including the Department of Health, the strategic health authority, the PCT, national regulators, other national organisations, local patient and public involvement and health scrutiny. It made 290 detailed recommendations.

3.2 The report, published in February 2013, attributed accountability to the Trust Board, but also pointed to a systemic failure by a range of national and local organisations to respond to concerns. This included the two local authorities who have both publicly acknowledged that they could have done more. The primary means for local authorities to do this is through the use of the health scrutiny powers available to them. There would be a reasonable expectation that if similar problems identified in Stafford were happening in Nottingham/ Nottinghamshire (and the report indicates that this should not be regarded as a one-off event that could not be repeated elsewhere in the NHS) the Councils would be aware and

take strong early action. Consequently, there is a need to ensure that health scrutiny operates as effectively as possible, and responds to recommendations for improvement.

3.3 In March 2013 the Panel considered the health scrutiny issues arising from the Francis Inquiry.

3.4 The Government published its full response to the Report on 19 November 2013, stating that it supports a 'fundamental culture change' across the health and social care system. The Executive Summary is attached at Appendix 1. The Government accepted the majority of recommendations, with 20 accepted in part, 57 accepted in principle only and 9 rejected.

3.5 The Government's response makes very little direct reference to local government health scrutiny, except in its detailed response to each recommendation. Extracts detailing the Government's response to the recommendations relating directly to health scrutiny are attached at Appendix 2. In its response to these recommendations the Government refers to Guidance being produced to help scrutiny committees understand and make use of the new powers and duties provided by the Local Authorities (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. It indicates that this Guidance will include information on developing co-ordination and co-operation between health scrutiny, Healthwatch and Health and Wellbeing Boards and support scrutiny committees in carrying out their role effectively. When the Guidance has been published, details will be provided to this Committee for its consideration.

3.6 In its response the Government stated that, in its view, the recommendation to give scrutiny committees powers of inspection would be duplicative, potentially burdensome and potentially create confusion about roles and responsibilities. The Government indicates that it intends to continue with the current arrangements whereby a health scrutiny committee can request that a provider allows it to visit premises, it can work with Local Healthwatch, which has 'enter and view' powers and/ or it can refer concerns to the Care Quality Commission who can carry out an inspection.

3.7 In terms of the recommendation relating to working with the Care Quality Commission (CQC), the Chair of the Health Scrutiny Panel recently met with the CQC's Local Compliance Manager to get a better understanding of how the CQC works locally and to share information, including about current issues and concerns. The Joint Health Scrutiny Committee also submitted information to inform the CQC's recent inspection of Nottingham University Hospitals NHS Trust.

4. List of attached information

4.1 The following information can be found in the appendices to this report:

Appendix 1 – Mid Staffordshire NHS Foundation Trust Public Inquiry Government Response November 2013 Executive Summary

Appendix 2 - Mid Staffordshire NHS Foundation Trust Public Inquiry Extract of responses to recommendations relating directly to health scrutiny

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013

Report to and minutes of Health Scrutiny Panel meeting held on 28 March 2013

Local Authorities (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

'Hard Truths: The Journey to Putting Patients First' Mid Staffordshire NHS Foundation Trust Public Inquiry Government Response November 2013

7. Wards affected

All

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Executive Summary

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

Robert Francis QC

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

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

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

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

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

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

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

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

PREVENTING PROBLEMS

Culture

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

Patient Safety

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

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

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

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

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

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

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

Openness and candour

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

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

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

Listening to patients

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

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

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

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

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

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

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

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

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

Safe staffing

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

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

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

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

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

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

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

DETECTING PROBLEMS QUICKLY

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

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

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

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

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

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

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

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

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

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

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

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

TAKING ACTION PROMPTLY

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

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

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

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

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

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

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

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

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

ENSURING ROBUST ACCOUNTABILITY

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

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

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

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

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

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

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

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

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

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

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

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

ENSURING STAFF ARE TRAINED AND MOTIVATED

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

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

‘Hard Truths: The Journey to Putting Patients First’

Mid Staffordshire NHS Foundation Trust Public Inquiry: Government Response

November 2013

Extract of responses to recommendations relating directly to health scrutiny

Recommendation 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’.

Accepted.

The Care Quality Commission has taken steps to engage Overview and Scrutiny Committees and Foundation Trust Governors, to increase their input to its new approach to inspection and monitoring.

All Overview and Scrutiny Committees now receive a two-monthly bulletin from the Care Quality Commission to update them on work and encourage feedback from their scrutiny reviews and activity. Each Overview and Scrutiny Committees has received a welcome letter from Professor Sir Mike Richards, the Chief Inspector of Hospitals. Local Trusts being inspected under the Care Quality Commission’s first wave of new in depth inspections have received a second letter inviting them to the public listening events and encouraging specific feedback about the Trusts.

The Care Quality Commission has put in place a contract with the Centre for Public Scrutiny to further develop information sharing and relationships with Overview and Scrutiny Committees across the regions. A sounding board of Overview and Scrutiny Committees was held in August 2013, which included encouraging Overview and Scrutiny Committees to access the Care Quality Commission’s local data to inform their scrutiny work programmes.

The Care Quality Commission and Monitor have worked together so that Monitor’s new statutory guidance for Governors provides briefing on the Care Quality Commission’s role and new approach to inspection. It sets out ways in which Governors can have an effective role in the Care Quality Commission’s monitoring and inspection, and how information should be shared.

Recommendation 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 the requirement of patient confidentiality.

Accepted.

Complaints data, along with other sources of feedback, have the potential to provide important information to local Healthwatch Organisations and Overview and Scrutiny Committees. It is important that Trusts respect patient confidentiality when releasing information on complaints to outside organisations but, subject to this caveat, we

consider that Trusts should seek to provide to these organisations with the complaints data that are requested.

The Department of Health will ensure that each quarter every hospital publishes information on the complaints it has received. This will include:

- the number of complaints received, as a percentage of patient interventions in that period;
- the number of complaints the hospital has been informed have subsequently been referred to the Ombudsman; and
- lessons learned and improvements made as a result of complaints.

The Department of Health will work with NHS England and other key partners to determine the most effective mechanism through which to achieve these outcomes. Rt Hon Ann Clwyd MP and Professor Tricia Hart's *Review of the Handling of Complaints in NHS Hospitals* recommends that:

- There should be Board-led scrutiny of complaints. All Boards and Chief Executives should receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action. These reports should be available to the Chief Inspector of Hospitals.
- Patients, patient representatives and local communities and local Healthwatch organisations should be fully involved in the development and monitoring of complaints' systems in all hospitals.

Local Healthwatch has an important role to play as patient champion, and it is right that individual local Healthwatch organisations have access to detailed information about complaints, subject to respect for patient confidentiality. Local Healthwatch have an important role to play in scrutinising complaints data locally.

The Department of Health will work with the Health and Social Care Information Centre to put complaints data into the existing NHS electronic data collection system, better enabling comparison between hospitals.

Recommendation 147

Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.

Accepted.

The Department of Health has worked with partners to develop guidance that will support effective scrutiny by local government of the commissioning and delivery of local services, helping to ensure they are effective and safe.

The guidance is aimed at local authorities, Health and Wellbeing Boards, NHS commissioners and providers, and local Healthwatch. The guidance underlines the importance of all partners in the system understanding their own and each other's roles and responsibilities, and working together to improve the quality of services.

The guidance also describes the new powers provided to local Healthwatch by the *Local Authorities (Public Health, Health and Wellbeing Boards and Health Scrutiny)*

Regulations 2013, and describes how Health and Wellbeing Boards and local Healthwatch can work collaboratively with local government scrutiny committees to ensure that the views and concerns of patients and public are heard throughout the scrutiny process.

The guidance is due to be published in November 2013.

Recommendation 149

Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.

Accepted.

The Department of Health has worked with partners to develop guidance that will support local authorities to carry out effective scrutiny of the commissioning and delivery of local services, helping to ensure they are effective and safe.

The guidance will help Local Authorities (along with local partners including NHS commissioners and providers, Health and Wellbeing Boards and Healthwatch) to understand the new powers and duties provided by the *Local Authorities (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.*

The Department is also delivering a range of programmes to increase the availability and transparency of data for local authorities, to support local democratic accountability including scrutiny processes.

The guidance is due to be published in November 2013.

Recommendation 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.

Accepted in principle.

Under current provisions, bodies carrying out local authority scrutiny functions have legal powers to require providers of NHS services to provide information and to attend scrutiny meetings to answer questions. This could include making a request to visit providers' premises. Where a body carrying out local authority scrutiny function had concerns about a specific provider, they could refer the matter to the Care Quality Commission, who have powers of inspection.

Meanwhile, local Healthwatch has the power to enter and view certain premises, as well as powers to provide information and refer concerns to local authority scrutiny bodies.

Giving further powers to local authorities would therefore be duplicative and potentially burdensome. It might also create confusion over roles and responsibilities.

The work of Local Authority health scrutiny is already integral to ensuring an appropriate inspection regime is in place locally. By working collaboratively with both providers and local Healthwatch, local authority scrutiny bodies can ensure that concerns from patients and the public trigger further investigation where necessary.

The Department of Health has worked with partners to develop guidance that will support local authorities to carry out effective scrutiny. The guidance describes the new powers and duties provided by the *Local Authorities (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013,* and underlines the importance of all partners in the local system working together to improve the quality of services.

The guidance is due to be published in November 2013.

Recommendation 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 accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.

Accepted.

While Quality Accounts provide information about local providers' performance, and should be flexible enough to support reporting at that level, they should also contain key information, in a common form, that allows direct comparisons to be made. This includes information on compliance with basic requirements and performance on key metrics including a set of outcome statistics.

The *National Health Service (Quality Accounts Regulations) 2010,* the *National Health Service (Quality Accounts) Amendment Regulations 2011* and the *National Health Service (Quality Accounts) Amendment Regulations 2012* set out prescribed information that must be included within Part 2 of the Quality Accounts.

This includes the following information:

- where the provider is subject to periodic review by the Care Quality Commission including:the date of the most recent review;
- the assessment made by the Care Quality Commission following the review;
- the action the provider intends to take to address the points made in that assessment by the Care Quality Commission; and
- any progress the provider has made in taking the action identified in the point above prior to the end of the reporting period.
- the value and banding of the summary hospital level mortality indicator; and
- other outcome measures including C. difficile per 100,000 bed days and the percentage of patients admitted to hospital who were risk assessed for venous thromboembolism. In addition, NHS England will issue guidance in October 2013 to include the patient component of the friends and family test as part of these measures.

In addition, the *National Health Service (Quality Accounts) Amendment Regulations 2012* require all Quality Accounts to include an annex that contains the statements of the:

- Overview and Scrutiny Committee or joint Overview and Scrutiny Committee carrying out the functions of that Overview and Scrutiny Committee;
- relevant clinical commissioning group or NHS England where 50% or more of the relevant health services that the provider directly provides or sub-contracts during the reporting period are under contracts or arrangements with NHS England; and
- local Healthwatch organisation.