Recommendations of the Francis Report

Accountability for implementation of the recommendations

These recommendations require every single person serving patients to contribute to a safer, committed and compassionate and caring service.

1. Implementing the recommendations

It is recommended that:

- All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;
- Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions;
- In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by other organisations;
- The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report.

2. The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires a common set of core values and standards shared throughout the system.

Putting the patient first

The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.

3. Clarity of values and principles

The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system’s common values, as well as the respective rights, legitimate expectations and obligations of patients.

4. The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.

5. In reaching out to patients, consideration should be given to including expectations in the NHS Constitution that:

- Staff put patients before themselves;
- They will do everything in their power to protect patients from avoidable harm;
- They will be honest and open with patients regardless of the consequences for themselves;
- Where they are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so;
- They will apply the NHS values in all their work.

6. The handbook to the NHS Constitution should be revised to include a much more prominent reference to the NHS values and their significance.

7. All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.

8 Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services.

Fundamental standards of behaviour
Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.

9. The NHS Constitution should include reference to all the relevant professional and managerial codes by which NHS staff are bound, including the Code of Conduct for NHS Managers.

10. The NHS Constitution should incorporate an expectation that staff will follow guidance and comply with standards relevant to their work, such as those produced by the National Institute for Health and Clinical Excellence and, where relevant, the Care Quality Commission, subject to any more specific requirements of their employers.

11. Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and pathways as possible.

12. Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.

A common culture made real throughout the system – an integrated hierarchy of standards of service

No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service. Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable.

13 The nature of standards

Standards should be divided into:

- Fundamental standards of minimum safety and quality – in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. There should be a defined set of duties to maintain and operate an effective system to ensure compliance;
- Enhanced quality standards – such standards could set requirements higher than the fundamental standards but be discretionary matters for commissioning and subject to availability of resources;
- Developmental standards which set out longer term goals for providers – these would focus on improvements in effectiveness and are more likely to be the focus of commissioners and progressive provider leadership than the regulator.

All such standards would require regular review and modification.

14. In addition to the fundamental standards of service, the regulations should include generic requirements for a governance system designed to ensure compliance with fundamental standards, and the provision and publication of accurate information about compliance with the fundamental and enhanced standards.

15. All the required elements of governance should be brought together into one comprehensive standard. This should require not only evidence of a working system but also a demonstration that it is being used to good effect.

16. Responsibility for setting standards

The Government, through regulation, but after so far as possible achieving consensus between the public and professional representatives, should provide for the fundamental standards which should define outcomes for patients that must be avoided. These should be limited to those matters that it is universally accepted should be avoided for individual patients who are accepted for treatment by a healthcare provider.

17. The NHS Commissioning Board together with Clinical Commissioning Groups should devise enhanced quality standards designed to drive improvement in the health service. Failure to comply with such standards should be a matter for performance management by commissioners rather than the regulator, although the latter should be charged with enforcing the provision by providers of accurate information about compliance to the public.
18. It is essential that professional bodies in which doctors and nurses have confidence are fully involved in the formulation of standards and in the means of measuring compliance.

Responsibility for, and effectiveness of, healthcare standards

19. Gaps between the understood functions of separate regulators

There should be a single regulator dealing both with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts.

Responsibility for regulating and monitoring compliance

20. The Care Quality Commission should be responsible for policing the fundamental standards, through the development of its core outcomes, by specifying the indicators by which it intends to monitor compliance with those standards. It should be responsible not for directly policing compliance with any enhanced standards but for regulating the accuracy of information about compliance with them.

21. The regulator should have a duty to monitor the accuracy of information disseminated by providers and commissioners on compliance with standards and their compliance with the requirement of honest disclosure. The regulator must be willing to consider individual cases of gross failure as well as systemic causes for concern.

22. The National Institute for Health and Clinical Excellence should be commissioned to formulate standard procedures and practice designed to provide the practical means of compliance, and indicators by which compliance with both fundamental and enhanced standards can be measured. These measures should include both outcome and process based measures, and should as far as possible build on information already available.

23. The measures formulated by the National Institute for Health and Clinical Excellence should include measures not only of clinical outcomes, but of the suitability and competence of staff, and the culture of organisations. The standard procedures and practice should include evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. This should include nursing staff on wards, as well as clinical staff. These tools should be created after appropriate input from specialties, professional organisations, and patient and public representatives, and consideration of the benefits and value for money of possible staff: patient ratios.

24. Compliance with regulatory fundamental standards must be capable so far as possible of being assessed by measures which are understood and accepted by the public and healthcare professionals.

25. It should be considered the duty of all specialty professional bodies, ideally together with the National Institute for Health and Clinical Excellence, to develop measures of outcome in relation to their work and to assist in the development of measures of standards compliance.

26. In policing compliance with standards, direct observation of practice, direct interaction with patients, carers and staff, and audit of records should take priority over monitoring and audit of policies and protocols. The regulatory system should retain the capacity to undertake in-depth investigations where these appear to be required.

27. The healthcare systems regulator should promote effective enforcement by: use of a low threshold of suspicion; no tolerance of non-compliance with fundamental standards; and allowing no place for favourable assumptions, unless there is evidence showing that suspicions are ill-founded or that deficiencies have been remedied. It requires a focus on identifying what is wrong, not on praising what is right.

28. Sanctions and interventions for non-compliance

Zero tolerance: A service incapable of meeting fundamental standards should not be permitted to continue. Breach should result in regulatory consequences attributable to an organisation in the case of a system failure and to individual accountability where individual professionals are responsible. Where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards, criminal liability should follow and failure to disclose breaches of these standards to the affected patient (or concerned relative) and a regulator should also attract regulatory consequences. Breaches not resulting in actual harm but which have exposed patients to a continuing risk of harm to which they would not otherwise have been exposed should also be regarded as unacceptable.

29. It should be an offence for death or serious injury to be caused to a patient by a breach of these regulatory requirements, or, in any other case of breach, where a warning notice in respect of the breach has been served and the notice has not been complied with. It should be a defence for the provider to prove that all reasonably
practicable steps have been taken to prevent a breach, including having in place a prescribed system to prevent such a breach.

Interim measures

30. The healthcare regulator must be free to require or recommend immediate protective steps where there is reasonable cause to suspect a breach of fundamental standards, even if it has yet to reach a concluded view or acquire all the evidence. The test should be whether it has reasonable grounds in the public interest to make the interim requirement or recommendation.

31. Where aware of concerns that patient safety is at risk, Monitor and all other regulators of healthcare providers must have in place policies which ensure that they constantly review whether the need to protect patients requires use of their own powers of intervention to inform a decision whether or not to intervene, taking account of, but not being bound by, the views or actions of other regulators.

32. Where patient safety is believed on reasonable grounds to be at risk, Monitor and any other regulator should be obliged to take whatever action within their powers is necessary to protect patient safety. Such action should include, where necessary, temporary measures to ensure such protection while any investigation required to make a final determination is undertaken.

33. Insofar as healthcare regulators consider they do not possess any necessary interim powers, the Department of Health should consider introduction of the necessary amendments to legislation to provide such powers.

34. Where a provider is under regulatory investigation, there should be some form of external performance management involvement to oversee any necessary interim arrangements for protecting the public.

35. Need to share information between regulators

Sharing of intelligence between regulators needs to go further than sharing of existing concerns, identified as risks. It should extend to all intelligence which when pieced together with that possessed by partner organisations may raise the level of concern. Work should be done on a template of the sort of information each organisation would find helpful.

36. Use of information for effective regulation

A coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real time as possible, and should be capable of use by regulators in assessing the risk of non-compliance. It must not only include statistics about outcomes, but must take advantage of all safety related information, including that capable of being derived from incidents, complaints and investigations.

Use of information about compliance by regulator from:

37. Quality accounts

Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them. To the extent that it is not practical in a written report to set out detail, this should be made available via each trust’s website. Reports should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information.

To make or be party to a wilfully or recklessly false statement as to compliance with safety or essential standards in the required quality account should be made a criminal offence

38. Complaints

The Care Quality Commission should ensure as a matter of urgency that it has reliable access to useful complaints information relevant to assessment of compliance with fundamental standards, and should actively seek this information out, probably via its local relationship managers. Any bureaucratic or legal obstacles to this should be removed.

39. The Care Quality Commission should introduce a mandated return from providers about patterns of complaints, how they were dealt with and outcomes.

40. It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.
41. **Patient safety alerts**

The Care Quality Commission should have a clear responsibility to review decisions not to comply with patient safety alerts and to oversee the effectiveness of any action required to implement them. Information-sharing with the Care Quality Commission regarding patient safety alerts should continue following the transfer of the National Patient Safety Agency’s functions in June 2012 to the NHS Commissioning Board.

42. **Serious untoward incidents**

Strategic Health Authorities/their successors should, as a matter of routine, share information on serious untoward incidents with the Care Quality Commission.

43. **Media**

Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.

44. Any example of a serious incident or avoidable harm should trigger an examination by the Care Quality Commission of how that was addressed by the provider and a requirement for the trust concerned to demonstrate that the learning to be derived has been successfully implemented.

45. **Inquests**

The Care Quality Commission should be notified directly of upcoming healthcare-related inquests, either by trusts or perhaps more usefully by coroners.

46. **Quality and risk profiles**

The Quality and Risk Profile should not be regarded as a potential substitute for active regulatory oversight by inspectors. It is important that this is explained carefully and clearly as and when the public are given access to the information.

47. **Foundation trust governors, scrutiny committees**

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’.

48. The Care Quality Commission should send a personal letter, via each registered body, to each foundation trust governor on appointment, inviting them to submit relevant information about any concerns to the Care Quality Commission.

49. Enhancement of monitoring and the importance of inspection

Routine and risk-related monitoring, as opposed to acceptance of self-declarations of compliance, is essential. The Care Quality Commission should consider its monitoring in relation to the value to be obtained from:

- The Quality and Risk Profile;
- Quality Accounts;
- Reports from Local Healthwatch;
- New or existing peer review schemes;
- Themed inspections.

50. The Care Quality Commission should retain an emphasis on inspection as a central method of monitoring non-compliance.

51. The Care Quality Commission should develop a specialist cadre of inspectors by thorough training in the principles of hospital care. Inspections of NHS hospital care providers should be led by such inspectors who should have the support of a team, including service user representatives, clinicians and any other specialism necessary because of particular concerns. Consideration should be given to applying the same principle to the independent sector, as well as to the NHS.

52. The Care Quality Commission should consider whether inspections could be conducted in collaboration with other agencies, or whether they can take advantage of any peer review arrangements available.

53. **Care Quality Commission independence, strategy and culture**

Any change to the Care Quality Commission’s role should be by evolution – any temptation to abolish this organisation and create a new one must be avoided.
54. Where issues relating to regulatory action are discussed between the Care Quality Commission and other agencies, these should be properly recorded to avoid any suggestion of inappropriate interference in the Care Quality Commission’s statutory role.

55. The Care Quality Commission should review its processes as a whole to ensure that it is capable of delivering regulatory oversight and enforcement effectively, in accordance with the principles outlined in this report.

56. The leadership of the Care Quality Commission should communicate clearly and persuasively its strategic direction to the public and to its staff, with a degree of clarity that may have been missing to date.

57. The Care Quality Commission should undertake a formal evaluation of how it would detect and take action on the warning signs and other events giving cause for concern at the Trust described in this report, and in the report of the first inquiry, and open that evaluation for public scrutiny.

58. Patients, through their user group representatives, should be integrated into the structure of the Care Quality Commission. It should consider whether there is a place for a patients’ consultative council with which issues could be discussed to obtain a patient perspective directly.

59. Consideration should be given to the introduction of a category of nominated board members from representatives of the professions, for example, the Academy of Medical Royal Colleges, a representative of nursing and allied healthcare professionals, and patient representative groups.

Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor’s healthcare systems regulatory functions

60. Consolidation of regulatory functions

The Secretary of State should consider transferring the functions of regulating governance of healthcare providers and the fitness of persons to be directors, governors or equivalent persons from Monitor to the Care Quality Commission.

61. A merger of system regulatory functions between Monitor and the Care Quality Commission should be undertaken incrementally and after thorough planning. Such a move should not be used as a justification for reduction of the resources allocated to this area of regulatory activity. It would be vital to retain the corporate memory of both organisations.

62. Improved patient focus

For as long as it retains responsibility for the regulation of foundation trusts, Monitor should incorporate greater patient and public involvement into its own structures, to ensure this focus is always at the forefront of its work.

63. Improved transparency

Monitor should publish all side letters and any rating issued to trusts as part of their authorisation or licence.

64. Authorisation of foundation trusts

The authorisation process should be conducted by one regulator, which should be equipped with the relevant powers and expertise to undertake this effectively. With due regard to protecting the public from the adverse consequences inherent to any reorganisation, the regulation of the authorisation process and compliance with foundation trust standards should be transferred to the Care Quality Commission, which should incorporate the relevant departments of Monitor.

65 Quality of care as a pre-condition for foundation trust applications

The NHS Trust Development Authority should develop a clear policy requiring proof of fitness for purpose in delivering the appropriate quality of care as a pre-condition to consideration for support for a foundation trust application.

66 Improving contribution of stakeholder opinions

The Department of Health, the NHS Trust Development Authority and Monitor should jointly review the stakeholder consultation process with a view to ensuring that:

- Local stakeholder and public opinion is sought on the fitness of a potential applicant NHS trust for foundation trust status and in particular on whether a potential applicant is delivering a sustainable service compliant with fundamental standards;
An accessible record of responses received is maintained;
The responses are made available for analysis on behalf of the Secretary of State, and, where an application is assessed by it, Monitor.

67. Focus on compliance with fundamental standards

The NHS Trust Development Authority should develop a rigorous process for the assessment as well as the support of potential applicants for foundation trust status. The assessment must include as a priority focus a review of the standard of service delivered to patients, and the sustainability of a service at the required standard.

68. No NHS trust should be given support to make an application to Monitor unless, in addition to other criteria, the performance manager (the Strategic Health Authority cluster, the Department of Health team, or the NHS Trust Development Authority) is satisfied that the organisation currently meets Monitor’s criteria for authorisation and that it is delivering a sustainable service which is, and will remain, safe for patients, and is compliant with at least fundamental standards.

69. The assessment criteria for authorisation should include a requirement that applicants demonstrate their ability to consistently meet fundamental patient safety and quality standards at the same time as complying with the financial and corporate governance requirements of a foundation trust.

70. Duty of utmost good faith

A duty of utmost good faith should be imposed on applicants for foundation trust status to disclose to the regulator any significant information material to the application and to ensure that any information is complete and accurate. This duty should continue throughout the application process, and thereafter in relation to the monitoring of compliance.

71. Role of Secretary of State

The Secretary of State’s support for an application should not be given unless he is satisfied that the proposed applicant provides a service to patients which is, at the time of his consideration, safe, effective and compliant with all relevant standards, and that in his opinion it is reasonable to conclude that the proposed applicant will continue to be able to do so for the foreseeable future. In deciding whether he can be so satisfied, the Secretary of State should have regard to the required public consultation and should consult with the healthcare regulator.

72. Assessment process for authorisation

The assessment for an authorisation of applicant for foundation trust status should include a full physical inspection of its primary clinical areas as well as all wards to determine whether it is compliant with fundamental safety and quality standards.

73. Need for constructive working with other parts of the system

The Department of Health’s regular performance reviews of Monitor (and the Care Quality Commission) should include an examination of its relationship with the Department of Health and whether the appropriate degree of clarity of understanding of the scope of their respective responsibilities has been maintained.

74. Enhancement of role of governors

Monitor and the Care Quality Commission should publish guidance for governors suggesting principles they expect them to follow in recognising their obligation to account to the public, and in particular in arranging for communication with the public served by the foundation trust and to be informed of the public’s views about the services offered.

75. The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest. They should produce an agreed published description of the role of the governors and how it is planned that they perform it. Monitor and the Care Quality Commission should review these descriptions and promote what they regard as best practice.

76. Arrangements must be made to ensure that governors are accountable not just to the immediate membership but to the public at large – it is important that regular and constructive contact between governors and the public is maintained.

77. Monitor and the NHS Commissioning Board should review the resources and facilities made available for the training and development of governors to enhance their independence and ability to expose and challenge deficiencies in the quality of the foundation trust’s services.
78. The Care Quality Commission and Monitor should consider how best to enable governors to have access to a similar advisory facility in relation to compliance with healthcare standards as will be available for compliance issues in relation to breach of a licence (pursuant to section 39A of the National Health Service Act 2006 as amended), or other ready access to external assistance.

79 **Accountability of providers’ directors**

There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.

80. A finding that a person is not a fit and proper person on the grounds of serious misconduct or incompetence should be a circumstance added to the list of disqualifications in the standard terms of a foundation trust’s constitution.

81. Consideration should be given to including in the criteria for fitness a minimum level of experience and/or training, while giving appropriate latitude for recognition of equivalence.

82. Provision should be made for regulatory intervention to require the removal or suspension from office after due process of a person whom the regulator is satisfied is not or is no longer a fit and proper person, regardless of whether the trust is in significant breach of its authorisation or licence.

83. If a “fit and proper person test” is introduced as recommended, Monitor should issue guidance on the principles on which it would exercise its power to require the removal or suspension or disqualification of directors who did not fulfil it, and the procedure it would follow to ensure due process.

84. Where the contract of employment or appointment of an executive or non-executive director is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit and proper person to hold such a post, licensed bodies should be obliged by the terms of their licence to report the matter to Monitor, the Care Quality Commission and the NHS Trust Development Authority.

85. Monitor and the Care Quality Commission should produce guidance to NHS and foundation trusts on procedures to be followed in the event of an executive or non-executive director being found to have been guilty of serious failure in the performance of his or her office, and in particular with regard to the need to have regard to the public interest in protection of patients and maintenance of confidence in the NHS and the healthcare system.

86. **Requirement of training of directors**

A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors.

87. **Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings**

87. Ensuring the utility of a health and safety function in a clinical setting

The Health and Safety Executive is clearly not the right organisation to be focusing on healthcare. Either the Care Quality Commission should be given power to prosecute 1974 Act offences or a new offence containing comparable provisions should be created under which the Care Quality Commission has power to launch a prosecution.

88. **Information sharing**

The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts’ practice in reporting fatalities and other serious incidents.

89. Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.

90 **Assistance in deciding on prosecutions**

In order to determine whether a case is so serious, either in terms of the breach of safety requirements or the consequences for any victims, that the public interest requires individuals or organisations to be brought to account for their failings, the Health and Safety Executive should obtain expert advice, as is done in the field of healthcare litigation and fitness to practise proceedings.
Enhancement of the role of supportive agencies

91 **NHS Litigation Authority**

Improvement of risk management

The Department of Health and NHS Commissioning Board should consider what steps are necessary to require all NHS providers, whether or not they remain members of the NHS Litigation Authority scheme, to have and to comply with risk management standards at least as rigorous as those required by the NHS Litigation Authority.

92. The financial incentives at levels below level 3 should be adjusted to maximise the motivation to reach level 3.

93. The NHS Litigation Authority should introduce requirements with regard to observance of the guidance to be produced in relation to staffing levels, and require trusts to have regard to evidence-based guidance and benchmarks where these exist and to demonstrate that effective risk assessments take place when changes to the numbers or skills of staff are under consideration. It should also consider how more outcome based standards could be designed to enhance the prospect of exploring deficiencies in risk management, such as occurred at the trust.

94 **Evidence-based assessment**

As some form of running record of the evidence reviewed must be retained on each claim in order for these reports to be produced, the NHS Litigation Authority should consider development of a relatively simple database containing the same information.

95 **Information sharing**

As the interests of patient safety should prevail over the narrow litigation interest under which confidentiality or even privilege might be claimed over risk reports, consideration should also be given to allowing the Care Quality Commission access to these reports.

96 The NHS Litigation Authority should make more prominent in its publicity an explanation comprehensible to the general public of the limitations of its standards assessments and of the reliance which can be placed on them.

97 **National Patient Safety Agency functions**

The National Patient Safety Agency’s resources need to be well protected and defined. Consideration should be given to the transfer of this valuable function to a systems regulator.

98 Reporting to the National Reporting and Learning System of all significant adverse incidents not amounting to serious untoward incidents but involving harm to patients should be mandatory on the part of trusts.

99 The reporting system should be developed to make more information available from this source. Such reports are likely to be more informative than the corporate version where an incident has been properly reported, and invaluable where it has not been.

100 Individual reports of serious incidents which have not been otherwise reported should be shared with a regulator for investigation, as the receipt of such a report may be evidence that the mandatory system has not been complied with.

101 While it may be impracticable for the National Patient Safety Agency or its successor to have its own team of inspectors, it should be possible to organise for mutual peer review inspections or the inclusion in Patient Environment Action Team representatives from outside the organisation. Consideration could also be given to involvement from time to time of a representative of the Care Quality Commission.

102 **Transparency, use and sharing of information**

Data held by the National Patient Safety Agency or its successor should be open to analysis for a particular purpose, or others facilitated in that task.

103 The National Patient Safety Agency or its successor should regularly share information with Monitor.

104 The Care Quality Commission should be enabled to exploit the potential of the safety information obtained by the National Patient Safety Agency or its successor to assist it in identifying areas for focusing its attention. There needs to be a better dialogue between the two organisations as to how they can assist each other.
105 Consideration should be given to whether information from incident reports involving deaths in hospital could enhance consideration of the hospital standardised mortality ratio.

106 Health Protection Agency

Coordination and publication of providers’ information on healthcare associated infections

The Health Protection Agency and its successor, should coordinate the collection, analysis and publication of information on each provider’s performance in relation to healthcare associated infections, working with the Health and Social Care Information Centre.

107 Sharing concerns If the Health Protection Agency or its successor, or the relevant local director of public health or equivalent official, becomes concerned that a provider’s management of healthcare associated infections is or may be inadequate to provide sufficient protection of patients or public safety, they should immediately inform all responsible commissioners, including the relevant regional office of the NHS Commissioning Board, the Care Quality Commission and, where relevant, Monitor, of those concerns. Sharing of such information should not be regarded as an action of last resort. It should review its procedures to ensure clarity of responsibility for taking this action.

108 Support for other agencies

Public Health England should review the support and training that health protection staff can offer to local authorities and other agencies in relation to local oversight of healthcare providers’ infection control arrangements.

Effective complaints handling

Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.

109 Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.

110 Lowering barriers Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.

111 Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.

112 Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.

113 Complaints handling

The recommendations and standards suggested in the Patients Association’s peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.

114 Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.

115 Investigations Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply:
- A complaint amounts to an allegation of a serious untoward incident;
- Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion;
- A complaint raises substantive issues of professional misconduct or the performance of senior managers;
- A complaint involves issues about the nature and extent of the services commissioned.

116 Support for complainants
Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.

117 A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.

118 Learning and information from complaints

Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.

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.

120 Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by the NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so.

121 The Care Quality Commission should have a means of ready access to information about the most serious complaints. Their local inspectors should be charged with informing themselves of such complaints and the detail underlying them.

122 Handling large-scale complaints

Large-scale failures of clinical service are likely to have in common a need for:

- Provision of prompt advice, counselling and support to very distressed and anxious members of the public;
- Swift identification of persons of independence, authority and expertise to lead investigations and reviews;
- A procedure for the recruitment of clinical and other experts to review cases;
- A communications strategy to inform and reassure the public of the processes being adopted;
- Clear lines of responsibility and accountability for the setting up and oversight of such reviews.

Such events are of sufficient rarity and importance, and requiring of coordination of the activities of multiple organisations, that the primary responsibility should reside in the National Quality Board.

Commissioning for standards

123 Responsibility for monitoring delivery of standards and quality

GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services. They should be an independent, professionally qualified check on the quality of service, in particular in relation to an assessment of outcomes. They need to have internal systems enabling them to be aware of patterns of concern, so that they do not merely treat each case on its individual merits. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients’ choice reality. A GP’s duty to a patient does not end on referral to hospital, but is a continuing relationship. They will need to take this continuing partnership with their patients seriously.

124 Duty to require and monitor delivery of fundamental standards

The commissioner is entitled to and should, wherever it is possible to do so, apply a fundamental safety and quality standard in respect of each item of service it is commissioning. In relation to each such standard, it should agree a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance by requiring redress for individual patients who have received substandard service to be offered by the provider. These must be consistent with fundamental standards enforceable by the Care Quality Commission.

125 Responsibility for requiring and monitoring delivery of enhanced standards

In addition to their duties with regard to the fundamental standards, commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards. They
can incentivise such improvements either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work.

126 Preserving corporate memory

The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups reformed, and guidance for commissioners on what they should expect to see in any organisational transitions amongst their providers.

127 Resources for scrutiny

The NHS Commissioning Board and local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of its providers’ services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.

128 Expert support

Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement expertise. When groups are too small to acquire such support, they should collaborate with others to do so.

129 Ensuring assessment and enforcement of fundamental standards through contracts

In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed.

130 Relative position of commissioner and provider

Commissioners – not providers – should decide what they want to be provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers and elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail.

131 Development of alternative sources of provision

Commissioners need, wherever possible, to identify and make available alternative sources of provision. This may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with providers.

Recommendations 132-138 have been omitted

Performance management and strategic oversight

139 The need to put patients first at all times

The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with.

140 Performance managers working constructively with regulators

Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including information about its judgement as to the safety of patients of the healthcare provider.

141 Taking responsibility for quality

Any differences of judgement as to immediate safety concerns between a performance manager and a regulator should be discussed between them and resolved where possible, but each should recognise its retained individual responsibility to take whatever action within its power is necessary in the interests of patient safety.

142 Clear lines of responsibility supported by good information flows
For an organisation to be effective in performance management, there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality.

143 Clear metrics on quality

Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.

144 Need for ownership of quality metrics at a strategic level

The NHS Commissioning Board should ensure the development of metrics on quality and outcomes of care for use by commissioners in managing the performance of providers, and retain oversight of these through its regional offices, if appropriate.

Patient, public and local scrutiny

145 Structure of Local Healthwatch

There should be a consistent basic structure for Local Healthwatch throughout the country, in accordance with the principles set out in Chapter 6: Patient and public local involvement and scrutiny.

146 Finance and oversight of Local Healthwatch

Local authorities should be required to pass over the centrally provided funds allocated to its Local Healthwatch, while requiring the latter to account to it for its stewardship of the money. Transparent respect for the independence of Local Healthwatch should not be allowed to inhibit a responsible local authority – or Healthwatch England as appropriate – intervening.

147 Coordination of local public scrutiny bodies

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

148 Training

The complexities of the health service are such that proper training must be available to the leadership of Local Healthwatch as well as, when the occasion arises, expert advice.

149 Expert assistance

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

150 Inspection powers

Scrubtny 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.

151 Complaints to MPs

MPs are advised to consider adopting some simple system for identifying trends in the complaints and information they received from constituents. They should also consider whether individual complaints imply concerns of wider significance than the impact on one individual patient.

Medical Training and education

For Francis recommendations on medical training and education (152-172), see BMJ Careers

Openness, transparency and candour

Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.
173 **Principles of openness, transparency and candour**

Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.

174 **Candour about harm**

Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.

175 **Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal representative).**

176 **Openness with regulators**

Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.

177 **Openness in public statements**

Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.

178 **Implementation of the duty**

Ensuring consistency of obligations under the duty of openness, transparency and candour

The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations.

179 **Restrictive contractual clauses**

“Gagging clauses” or non-disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.

180 **Candour about incidents**

Guidance and policies should be reviewed to ensure that they will lead to compliance with Being Open, the guidance published by the National Patient Safety Agency.

181 **Enforcement of the duty**

Statutory duties of candour in relation to harm to patients

A statutory obligation should be imposed to observe a duty of candour:

- On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request;
- On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable.

The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.

182 **Statutory duty of openness and transparency**
There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation, where given in compliance with a statutory obligation on the organisation to provide it.

183 Criminal liability

It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation:

- Knowingly to obstruct another in the performance of these statutory duties;
- To provide information to a patient or nearest relative intending to mislead them about such an incident;
- Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties

184 Enforcement by the Care Quality Commission

Observance of the duty should be policed by the Care Quality Commission, which should have powers in the last resort to prosecute in cases of serial non-compliance or serious and wilful deception. The Care Quality Commission should be supported by monitoring undertaken by commissioners and others.

Nursing

Recommendations on nursing (185-213) have been omitted

Leadership

214 Shared training

A leadership staff college or training system, whether centralised or regional, should be created to: provide common professional training in management and leadership to potential senior staff; promote healthcare leadership and management as a profession; administer an accreditation scheme to enhance eligibility for consideration for such roles; promote and research best leadership practice in healthcare.

215 Shared code of ethics

A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.

216 Leadership framework

The leadership framework should be improved by increasing the emphasis given to patient safety in the thinking of all in the health service. This could be done by, for example, creating a separate domain for managing safety, or by defining the service to be delivered as a safe and effective service.

217 Common selection criteria

A list should be drawn up of all the qualities generally considered necessary for a good and effective leader. This in turn could inform a list of competences a leader would be expected to have.

218 Enforcement of standards and accountability

Serious non-compliance with the code, and in particular, non-compliance leading to actual or potential harm to patients, should render board-level leaders and managers liable to be found not to be fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them from holding such positions in future.

219 A regulator as an alternative

An alternative option to enforcing compliance with a management code of conduct, with the risk of disqualification, would be to set up an independent professional regulator. The need for this would be greater if it were thought appropriate to extend a regulatory requirement to a wider range of managers and leaders. The proportionality of such a step could be better assessed after reviewing the experience of a licensing provision for directors.

220 Accreditation

A training facility could provide the route through which an accreditation scheme could be organised. Although this might be a voluntary scheme, at least initially, the objective should be to require all leadership posts to be
filled by persons who experience some shared training and obtain the relevant accreditation, enhancing the spread of the common culture and providing the basis for a regulatory regime.

221 Ensuring common standards of competence and compliance

Consideration should be given to ensuring that there is regulatory oversight of the competence and compliance with appropriate standards by the boards of health service bodies which are not foundation trusts, of equivalent rigour to that applied to foundation trusts.

Professional regulation of fitness to practise

222 General Medical Council

Systemic investigation where needed

The General Medical Council should have a clear policy about the circumstances in which a generic complaint or report ought to be made to it, enabling a more proactive approach to monitoring fitness to practise.

223 Enhanced resources

If the General Medical Council is to be effective in looking into generic complaints and information it will probably need either greater resources, or better cooperation with the Care Quality Commission and other organisations such as the Royal Colleges to ensure that it is provided with the appropriate information.

224 Information sharing

Steps must be taken to systematise the exchange of information between the Royal Colleges and the General Medical Council, and to issue guidance for use by employers of doctors to the same effect.

225 Peer reviews

The General Medical Council should have regard to the possibility of commissioning peer reviews pursuant to section 35 of the Medical Act 1983 where concerns are raised in a generic way, in order to be advised whether there are individual concerns. Such reviews could be jointly commissioned with the Care Quality Commission in appropriate cases.

Nursing and Midwifery Council

Recommendations relating to nursing and midwifery council (226-235) have been omitted

Caring for the elderly

Approaches applicable to all patients but requiring special attention for the elderly

236 Identification of who is responsible for the patient

Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient’s case, so that patients and their supporters are clear who is in overall charge of a patient’s care.

237 Teamwork

There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.

238 Communication with and about patients

Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds:

- All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors.
- Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients.
- The NHS should develop a greater willingness to communicate by email with relatives.
- The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered.
Information about an older patient’s condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.

239 Continuing responsibility for care

The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.

240 Hygiene

All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.

241 Provision of food and drink

The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.

242 Medicines administration

In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.

243 Recording of routine observations

The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.

Information

244 Common information practices, shared data and electronic records

There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems:

- Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way.
- Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry.
- Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered.
- Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input.
- Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements.

Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements.

245 Board accountability

Each provider organisation should have a board level member with responsibility for information.

246 Comparable quality accounts

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.

**Accountability for quality accounts**

Healthcare providers should be required to lodge their quality accounts with all organisations commissioning healthcare providers should be required to have their quality accounts independently audited. Auditors should be given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts.

Each quality account should be accompanied by a declaration signed by all directors in office at the date of the account certifying that they believe the contents of the account to be true, or alternatively a statement of explanation as to the reason any such director is unable or has refused to sign such a declaration.

It should be a criminal offence for a director to sign a declaration of belief that the contents of a quality account are true if it contains a misstatement of fact concerning an item of prescribed information which he/she does not have reason to believe is true at the time of making the declaration.

**Regulatory oversight of quality accounts**

The Care Quality Commission and/or Monitor should keep the accuracy, fairness and balance of quality accounts under review and should be enabled to require corrections to be issued where appropriate. In the event of an organisation failing to take that action, the regulator should be able to issue its own statement of correction.

**Access to data**

It is important that the appropriate steps are taken to enable properly anonymised data to be used for managerial and regulatory purposes.

**Access to quality and risk profile**

The information behind the quality and risk profile – as well as the ratings and methodology – should be placed in the public domain, as far as is consistent with maintaining any legitimate confidentiality of such information, together with appropriate explanations to enable the public to understand the limitations of this tool.

**Access for public and patient comments**

While there are likely to be many different gateways offered through which patient and public comments can be made, to avoid confusion, it would be helpful for there to be consistency across the country in methods of access, and for the output to be published in a manner allowing fair and informed comparison between organisations.

**Using patient feedback**

Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near “real time” as possible, even if later adjustments have to be made.

**Follow up of patients**

A proactive system for following up patients shortly after discharge would not only be good “customer service”, it would probably provide a wider range of responses and feedback on their care.

**Role of the Health and Social Care Information Centre**

The Information Centre should be tasked with the independent collection, analysis, publication and oversight of healthcare information in England, or, with the agreement of the devolved governments, the United Kingdom. The information functions previously held by the National Patient Safety Agency should be transferred to the NHS Information Centre if made independent.

The Information Centre should continue to develop and maintain learning, standards and consensus with regard to information methodologies, with particular reference to comparative performance statistics.

The Information Centre, in consultation with the Department of Health, the NHS Commissioning Board and the Parliamentary and Health Service Ombudsman, should develop a means of publishing more detailed breakdowns of clinically related complaints.

**Information standards**
The standards applied to statistical information about serious untoward incidents should be the same as for any other healthcare information and in particular the principles around transparency and accessibility. It would, therefore, be desirable for the data to be supplied to, and processed by, the Information Centre and, through them, made publicly available in the same way as other quality related information.

261 The Information Centre should be enabled to undertake more detailed statistical analysis of its own than currently appears to be the case.

262 Enhancing the use, analysis and dissemination of healthcare information

All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them:

- Effective real-time information on the performance of each of their services against patient safety and minimum quality standards;
- Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction.

In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations such as the medical Royal Colleges.

The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment.

It must be recognised to be the professional duty of all healthcare professionals to collaborate in the provision of information required for such statistics on the efficacy of treatment in specialties.

263 In the case of each specialty, a programme of development for statistics on the efficacy of treatment should be prepared, published, and subjected to regular review.

265 The Department of Health, the Information Centre and the Care Quality Commission should engage with each representative specialty organisation in order to consider how best to develop comparative statistics on the efficacy of treatment in that specialty, for publication and use in performance oversight, revalidation, and the promotion of patient knowledge and choice.

266 In designing the methodology for such statistics and their presentation, the Department of Health, the Information Centre, the Care Quality Commission and the specialty organisations should seek and have regard to the views of patient groups and the public about the information needed by them.

267 All such statistics should be made available online and accessible through provider websites, as well as other gateways such as the Care Quality Commission.

268 Resources

Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry.

269 Improving and assuring accuracy

The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved.

270 There is a need for a review by the Department of Health, the Information Centre and the UK Statistics Authority of the patient outcome statistics, including hospital mortality and other outcome indicators. In particular, there could be benefit from consideration of the extent to which these statistics can be published in a form more readily useable by the public.

271 To the extent that summary hospital-level mortality indicators are not already recognised as national or official statistics, the Department of Health and the Health and Social Care Information Centre should work towards establishing such status for them or any successor hospital mortality figures, and other patient outcome statistics, including reports showing provider-level detail.

272 There is a demonstrable need for an accreditation system to be available for healthcare-relevant statistical methodologies. The power to create an accreditation scheme has been included in the Health and Social Care Act 2012, it should be used as soon as practicable.
Coroners and inquests

Making more of the coronial process in healthcare-related deaths

273 Information to coroners

The terms of authorisation, licensing and registration and any relevant guidance should oblige healthcare providers to provide all relevant information to enable the coroner to perform his function, unless a director is personally satisfied that withholding the information is justified in the public interest.

274 There is an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest.

275 Independent medical examiners

It is of considerable importance that independent medical examiners are independent of the organisation whose patients’ deaths are being scrutinised.

276 Sufficient numbers of independent medical examiners need to be appointed and resourced to ensure that they can give proper attention to the workload.

277 Death certification

National guidance should set out standard methodologies for approaching the certification of the cause of death to ensure, so far as possible, that similar approaches are universal.

278 It should be a routine part of an independent medical examiners’s role to seek out and consider any serious untoward incidents or adverse incident reports relating to the deceased, to ensure that all circumstances are taken into account whether or not referred to in the medical records.

279 So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient’s case or treatment.

280 Appropriate and sensitive contact with bereaved families

Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.

281 It is important that independent medical examiners and any others having to approach families for this purpose have careful training in how to undertake this sensitive task in a manner least likely to cause additional and unnecessary distress.

282 Information for, and from, inquests

Coroners should send copies of relevant Rule 43 reports to the Care Quality Commission.

283 Guidance should be developed for coroners’ offices about whom to approach in gathering information about whether to hold an inquest into the death of a patient. This should include contact with the patient’s family.

284 Appointment of assistant deputy coroners

The Lord Chancellor should issue guidance as to the criteria to be adopted in the appointment of assistant deputy coroners.

285 Appointment of assistant deputy coroners

The Chief Coroner should issue guidance on how to avoid the appearance of bias when assistant deputy coroners are associated with a party in a case.

286 Impact assessments before structural change

Impact and risk assessments should be made public, and debated publicly, before a proposal for any major structural change to the healthcare system is accepted. Such assessments should cover at least the following issues:
What is the precise issue or concern in respect of which change is necessary?
Can the policy objective identified be achieved by modifications within the existing structure?
How are the successful aspects of the existing system to be incorporated and continued in the new system?
How are the existing skills which are relevant to the new system to be transferred to it?
How is the existing corporate and individual knowledge base to be preserved, transferred and exploited?
How is flexibility to meet new circumstances and to respond to experience built into the new system to avoid the need for further structural change?
How are necessary functions to be performed effectively during any transitional period?
What are the respective risks and benefits to service users and the public and, in particular, are there any risks to safety or welfare?

287 The Department of Health should together with healthcare systems regulators take the lead in developing through obtaining consensus between the public and healthcare professionals, a coherent, and easily accessible structure for the development and implementation of values, fundamental, enhanced and developmental standards as recommended in this report.

289 Clinical input The Department of Health should ensure that there is senior clinical involvement in all policy decisions which may impact on patient safety and well-being.

289 Experience on the front line

Department of Health officials need to connect more to the NHS by visits, and most importantly by personal contact with those who have suffered poor experiences. The Department of Health could also be assisted in its work by involving patient/service user representatives through some form of consultative forum within the Department.

290 The Department of Health should promote a shared positive culture by setting an example in its statements by being open about deficiencies, ensuring those harmed have a remedy, and making information publicly available about performance at the most detailed level possible.