Appendix 1: Executive Summary

Introduction

1.

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

2.

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

3.

Robert Francis' first independent inquiry looked at what went wrong inside the Trust and reported in 2010. Since then, we have

taken action to strengthen the focus on the quality of care and the safeguards to protect patients from harm, including through the work of the National Quality Board, the Nursing and Care Quality Forum, the improved processes for Foundation Trust authorisation, and the introduction of dignity and nutrition inspections amongst many other measures.

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

A.

Preventing problems

B.

Detecting problems quickly

C.

Taking action promptly

D.

Ensuring robust accountability

E.

Ensuring staff are trained and

motivated

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



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

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

A. Preventing Problems

7.

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

8.

The measures in this document – radical transparency, excellence in leadership, clarity of accountability, consequences for failure and rewards for the very best – will together put in place the action needed to revitalise the

culture of the NHS around a consistent focus on the needs of the patients it serves.

Time to Care

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

Safety in the DNA of the NHS – The Berwick Review

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

B. Detecting Problems Quickly

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

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



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

Expert Inspectors, not Generalists

12.

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

13.

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

Ratings – A Single Balanced Version of the Truth

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

Chief Inspector of Social Care

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

Publication of Individual Speciality Outcomes

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



head and neck surgery and thyroid and endocrine surgery.

Penalties for Disinformation, and a Statutory Duty of Candour

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

care has caused death or serious injury, and to provide an explanation, will reinforce the existing contractual duty.

A Ban on Clauses Intended to Prevent Public Interest Disclosures

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

Complaints Review

19. A review of best practice on complaints will ensure that when problems are raised, they are heard, addressed and acted upon, and seen as vital information for improvement rather than irritations to be managed defensively.

C. Taking Action Promptly

Fundamental Standards

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

Time Limited Failure Regime for Quality as Well as Finance

21.

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

22.

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

23.

In the first stage, the Chief Inspector will require the hospital board to work with its commissioners to improve, within a fixed time period, but the Care Quality Commission will not be responsible for making improvement happen. That will first be a task for the Board of the hospital, working with its commissioners. In the second stage, if the hospital with commissioners is unable to resolve its own problems, then the Care Quality Commission would call in Monitor or the NHS Trust Development Authority to take action. In the final stage, where fundamental problems in the hospital mean that

its problems have not been resolved, the Chief Inspector will initiate a failure regime, in which the Board could be suspended or the hospital put into administration, whilst ensuring continuity of care.

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

D. Ensuring Robust Accountability

Health and Safety Executive to use Criminal Sanctions

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

Faster and More Proactive Professional Regulation

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

Barring Failed NHS Managers

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

Clear Responsibilities for Tackling Failure

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

E. Ensuring Staff are Trained and Motivated

HCA Training before Nursing and other Degrees

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



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

Revalidation for Nurses

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

Code of Conduct and Minimum Training for Health and Care Assistants

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

Barring System for Healthcare Assistants

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

Attracting Professional and External Leaders to Senior Management Roles

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

Frontline Experience for Department of Health Staff

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

Next Steps

35.

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

36.

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

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

Robert Francis QC

1.

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

2.

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

3.

At heart, Robert Francis' report2 is a powerful call to action on tackling invidious aspects of NHS culture that have arguably become more pronounced as the health service has become busier and the needs of patients more complex.

4.

Our NHS is rightly celebrated, performing incredible feats at the cutting edge of medicine and surgery. Its staff, in the vast majority of cases, are dedicated, skilled, kind and committed people. Yet in parts it is failing, sometimes atrociously, in the very basics of care: failing to ensure patients have food they can eat and water to drink; failing

to provide the correct dose of medicine or pain relief at the right time; too often failing vulnerable people; failing to listen to what patients and families say or to offer a kind word or hand when one is most needed.

5.

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

6.

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



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

7.

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

8.

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

9.

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

Action Since the First Inquiry

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

(a)

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

(b)

Openness, transparency and candour

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

(c)

Leadership – the NHS Leadership Academy was established in 2012 and

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

(d)

Compassion and care – Compassion in Practice3 (the nursing, midwifery and care staff vision and strategy for England) was launched in December 2012. It is based on the values and behaviours of the "6Cs" – Care, Compassion, Competence, Communication, Courage and Commitment. Over the

last three months nurses, midwives and care staff, as well as stakeholders at national and organisational level, have developed implementation plans to support the delivery of the values and behaviours of the "6Cs". In addition, the Government has announced a £13 million innovation fund for the training and education of unregulated health professionals and Skills for Health and Skills for Care have been developing minimum training standards and a code of conduct for healthcare support workers and adult social care workers in England.

(e)

Information – from April 2013, a network of local and regional Quality Surveillance Groups (QSGs) will bring together commissioners, regulators, local Healthwatch representatives and other bodies on a regular basis to share information and intelligence about quality across the system and proactively spot potential problems. Also from April 2013, Quality Accounts will include comparable data from a set of quality indicators linked to the NHS Outcomes Framework including the summary hospital-level

mortality indicator, infection rates and reported levels of patient safety incidents. More generally, the Power of Information4 sets out the Department's ten-year framework for transforming information for health and care.

11.

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

12.

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

13.

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

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

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