

. No.	Recommendation	Hard Truths Government response	Progress update
1	<p>It is recommended that:</p> <ul style="list-style-type: none"> 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. 	<p>Accepted.</p> <p>The Inquiry made recommendations aimed at national organisations both by name and by implication because of the nature of their responsibilities within the newly reformed system. This document includes a detailed account from each of these organisations on what they have already done to implement recommendations directed to them and what further action they plan to take. Many organisations have published updates separately on their own websites.</p> <p>In addition, a number of recommendations were aimed at NHS Trusts and NHS Foundation Trusts.</p> <p>The Secretary of State wrote to all Trust Chairs in February 2013 asking them to hold listening events with their staff to hear what they have learnt from the Inquiry findings, and how they best think safe, effective and compassionate care can be delivered in an NHS managing a growing workload within a tight financial context. He followed this up with a letter on 26 March asking them to set out how they intend to respond to the Inquiry's conclusions before the end of 2013. Some Trusts have already issued a response. We would expect these responses to be placed on Trust websites. To maintain momentum, we would encourage all NHS trusts and NHS Foundation Trusts to use the opportunity this further response to the Inquiry presents to continue these local conversations. Leadership teams that put patients first recognise their organisations rely on the skill, motivation and behaviour of the people providing care to patients to drive improvements in safety, quality and compassionate care.</p> <p>The Government's initial response to the Inquiry, <u>Patients First and Foremost</u> published in March 2013, set out a radical programme to prioritise care, improve transparency and ensure that where poor care is detected there is clear action and clear accountability. Informed by the six independent reviews and more detailed work over the summer, <u>Hard Truths: the Journey to Putting Patients First</u> builds on this to provide a detailed response to each of the 290 recommendations made by the Inquiry. The Department of Health will lead the system in providing an annual report on progress each Autumn.</p> <p>The Health Select Committee confirmed in <u>3rd Report After Francis – making a difference</u>, published in September 2013, that it agrees with the Inquiry's recommendation that it should monitor implementation of all his recommendations. Specifically, the Committee proposes to enhance its scrutiny of regulation of healthcare professionals by taking public evidence each year from the Professional Standards Authority for Health and Social Care on the regulatory environment and the performance of each professional regulator, based on the Professional Standards Authority's own performance reviews. The Government is publishing its response to the Health Select Committee's report in parallel with Hard Truths.</p>	<p><u>Hard Truths: the Journey to Putting Patients First</u> published in November 2013 provided an integrated and detailed response to each of the 290 recommendations made by the Inquiry from every part of the health and care system. As part of the Department of Health's commitment to leading the system in providing an annual progress report, this document sets out what progress has been made towards implementing the actions set out in <i>Hard Truths</i> for each recommendation over the last year.</p> <p>The Department of Health know that local conversations in NHS Foundation Trusts and NHS trusts on the learning from Francis have continued throughout the year with the focus increasingly shifting towards on driving further improvements in safety, quality and compassionate care across all health and care sectors and settings.</p>
2	<p>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:</p> <ul style="list-style-type: none"> A common set of shared core values and standards shared throughout the system. Leadership at all levels from ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards; 	<p>Accepted.</p> <p>Shared core values and standards:</p> <ul style="list-style-type: none"> We will continue to use and promote the core values and expectations for the NHS set out in the NHS Constitution. The development of values based recruitment by Health Education England will reinforce the importance of values as the driving force of the NHS. The Care Quality Commission has conducted a major consultation on a new set of fundamental standards of care which will set out the inviolable principles of safe, effective and compassionate care that must underpin all care in the future. 	<p>The Department of Health has put in place a number of measures to address the elements of this recommendation. The detail of what the Department of Health have done is set out in the report on progress 'Culture Change in the NHS - Applying the Lessons of the Francis Inquiry' and in the updates we have provided on progress against other recommendations made by Sir Robert Francis QC.</p> <p>Among those measures are:</p> <p>Shared core values and standards</p> <ul style="list-style-type: none"> The Department of Health is consulting on a number of measures in relation to the NHS Constitution in response to the recommendations

<ul style="list-style-type: none"> • A system which recognises and applies the values of transparency, honesty and candour; • Freely available, useful, reliable and full information on attainment of the values and standards; • A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system. 	<ul style="list-style-type: none"> • The introduction of a new and robust inspection regime is an important shift in the way nationally the system will ensure poor care is identified and tackled. <p>Leadership at all levels</p> <ul style="list-style-type: none"> • We recognise the importance of leadership at all levels in ensuring that we prevent terrible failures of care of the kind we saw at Mid Staffordshire NHS Foundation Trust, and welcome the connection made in this recommendation between effective leadership and the engagement of staff. • The NHS Leadership Academy is developing and implementing a wide ranging programme of leadership support at all levels of the NHS, with a strong emphasis on values. <p>Information on the attainment of the values and standards</p> <ul style="list-style-type: none"> • We agree that the NHS needs to do much more to put in place a transparent approach to providing care and to working with patients. The shift to greater transparency is the foundation for the culture of honesty and candour that this recommendation calls for. • We are putting in place legal changes that place a statutory duty of candour on healthcare providers and which create a new offence of providing false or misleading information. <p>Measuring cultural health</p> <ul style="list-style-type: none"> • We agree that it is important to ensure there is a clear understanding of the cultural health of different parts of the NHS. Regular inspection will provide the basis for a new, clear, transparent system of ratings that will be accessible to the public. All acute hospitals in England will have been inspected by the end of 2015. • The Care Quality Commission is developing a set of indicators for inspecting all providers of NHS care, and this will permit judgements to be made about the culture of the organisation in question as well as other elements of its performance. • In June 2013, the Care Quality Commission issued <i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i>. In this, the Care Quality Commission suggested that a ‘well-led’ service is one where there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation, and an open, fair and transparent culture that listens and learns from people’s views and experiences to make improvements. They confirmed their plan was to encompass an assessment of aspects of governance, leadership and culture as part of its inspections to assess whether a service is ‘well-led’. • The boards of NHS organisations at all levels have a central responsibility to pay close attention to the culture of their organisation, actively dealing with cultural risks and seeking improvements in their organisation’s culture, drawing on support mechanisms such as the cultural barometer that is being developed by the National Nursing Research Unit at King’s College London along with other organisations. We would expect boards to be transparent about this with patients and the public. 	<p>made in the Inquiry report.</p> <ul style="list-style-type: none"> • Publication of a values-based recruitment framework to support recruiting for values. • Fundamental standards of safety and quality incorporated into the requirements for providers registered with the Care Quality Commission. • A new, robust inspection regime in place for hospitals, primary care and social care. <p>Leadership at all levels</p> <ul style="list-style-type: none"> • NHS Leadership Academy programmes launched to support leaders from ward to board to lead for safer, more compassionate care. • Launch of the executive fast-track programme to increase the number of executive leaders in the NHS from clinical and non-NHS backgrounds. <p>Information on the attainment of the values and standards</p> <ul style="list-style-type: none"> • The Department of Health and NHS England have made available an unprecedented amount of data on safety and outcomes on the ‘myNHS’ website. • The statutory duty of candour applies to NHS care now and will apply to all Care Quality Commission registered care from April 2015. • New inspection model for hospitals now being used across the NHS. <p>Measuring cultural health</p> <ul style="list-style-type: none"> • New system of ratings in place, and the Care Quality Commission inspection model includes the assessment of how ‘well led’ an organisation is. • The ‘myNHS’ website includes hospital-level data on the ‘friends and family’ test; whether an organisation is recommended by staff; and on open and honest reporting.
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3	<p>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 expectation and obligations of patients.</p>	<p>Accepted.</p> <p>We agree that the <i>NHS Constitution</i> should be the central reference point for all NHS patients and staff. The Constitution sets out principles and values to guide the NHS, as well as rights, pledges and responsibilities for patients and staff, and it has a powerful role to play in shaping the culture of the NHS. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities (in the exercise of their public health functions) are required by law to take account of the NHS Constitution in their decisions and actions. NHS England and clinical commissioning groups and Health Education England also have a legal duty to promote the Constitution.</p> <p>We recognise that levels of awareness of the Constitution are low among patients, the public and staff, and that we must raise the profile of the Constitution if it is to genuinely become the first reference point for patients and staff. To achieve this, the Department of Health, NHS England, Health Education England and clinical commissioning groups are working with relevant partners to embed and promote the Constitution across the system. The Department of Health is also developing options to increase the impact of the Constitution so that patients and the public understand their rights and responsibilities and are clear about what to do when their expectations are not met.</p>	<p>The Department of Health sought advice from an independent Expert Advisory Group about how to increase impact and raise awareness of the NHS Constitution amongst the public and patients. On 13 March 2014 the Expert Advisory Group published its advice in a report to the Secretary of State for Health and relevant system bodies, outlining how to embed and strengthen the impact of the NHS Constitution within the system. For example, the Department of Health has published a new guide which helps patients and the public understand how to give feedback and make complaints if the standards described in the NHS Constitution are not met. The Department will continue working with key partners to consider ways to increase the impact of the NHS Constitution</p>
4	<p>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.</p>	<p>Accepted.</p> <p>In the <i>Statement of Common Purpose</i>, all the leaders of the health and care system have personally committed to the values of the Constitution.</p> <p>The Constitution sets out the following values for the NHS:</p> <ul style="list-style-type: none"> • Working together for patients • Respect and dignity • Commitment to quality of care • Compassion • Improving lives • Everyone counts. <p>The Constitution notes that these values should underpin everything the NHS does and 'provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS'.</p> <p>In response to this recommendation, the Department brought forward the values section so that it appears early in the document (directly following the principles section) and re-ordered the values so that they start with 'working together for patients,' in the updated Constitution published on 26 March 2013. The text of this value explicitly states that 'patients come first in everything we do.' The work we are currently undertaking with stakeholders to increase awareness levels of the Constitution, as well as increase its impact, seeks to ensure that everyone is informed by the ethos that patients come first.</p> <p>We note that Principle 4 of the Constitution currently states that 'the NHS aspires to put patients at the heart of everything it does.' The Department of Health will consult on how this statement might be strengthened when we next update the Constitution.</p>	<p>Sir Robert Francis QC was clear in his Inquiry report that the principal message of the NHS Constitution should be that patients and their safety come first. In <i>Hard Truths</i>, the Department of Health committed to strengthening the NHS Constitution to make this clearer for patients, staff and the public. To this end, The Government has launched a consultation into, amongst other things, refreshing the NHS Constitution to reflect the recommendations made by Sir Robert Francis QC. The key elements are:</p> <ul style="list-style-type: none"> • duty of candour; • safe care and avoidable harm; • staff guidance, and; • a patient-centred NHS.
5	<p>In reaching out to patients, consideration</p>	<p>Accepted.</p>	<p>Sir Robert Francis QC was clear in his Inquiry report that the principal message</p>

	<p>should be given to including expectations in the NHS Constitution that:</p> <ul style="list-style-type: none"> • 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. 	<p>The <i>NHS Constitution</i> already addresses some of the issues highlighted in this recommendation, and when it is next updated the Department of Health will consult with stakeholders on how to best reflect other issues.</p> <p>We agree that staff should be honest and open with patients, and the Constitution already makes clear that these are staff responsibilities. The Constitution also includes an expectation that staff will raise concerns early, in the public interest about risk, malpractice or wrongdoing (such as a risk to patient safety, fraud, or breaches of patient confidentiality) and a pledge that their employer will support staff to raise these concerns and act upon them. In addition, we are introducing a statutory duty of candour on all health providers, making it a requirement for them to be open and honest where there have been failings in care (see recommendations 174 and 181 for more on our response about openness and candour).</p> <p>We agree with the principle that patients should come first in everything the NHS does, and this is explicitly stated in the Constitution. We do not propose to include the more explicit wording 'staff put patients before themselves' suggested by the Inquiry, as we have heard concerns from stakeholders that such an expectation may also have a negative impact on staff safety and wellbeing.</p> <p>The Constitution also already states that its values should underpin everything the NHS does. We agree with the importance of protecting patients from avoidable harm. The Constitution already includes an expectation that staff will raise concerns early, such as a risk to patient safety; however, there is scope to further reflect the issue of staff protecting patients from avoidable harm. More broadly, as part of their code of conduct, regulated healthcare professionals already have a duty to comply with standardised procedures that protect patients from avoidable harm. Other work to help protect patients from avoidable harm includes introducing the new fundamental standards of care which will set out the level below which care should not fall (refer to the responses to recommendations 13-18 for more information), and ensuring that the NHS takes a zero tolerance approach to all healthcare associated infections (refer to the response to recommendation 107 for more information).</p> <p>When the Constitution and the <i>Handbook to the NHS Constitution</i> are next updated, the Department of Health will consider, in consultation with stakeholders, how best to further reflect the importance of staff:</p> <ul style="list-style-type: none"> • protecting patients from avoidable harm • directing patients to other sources of assistance, in situations where they themselves are unable to help. 	<p>of the NHS Constitution should be that patients and their safety come first. In <i>Hard Truths</i>, the Department of Health committed to strengthening the NHS Constitution to make this clearer for patients, staff and the public. To this end, The Government has launched a consultation into, amongst other things, refreshing the NHS Constitution to reflect the recommendations made by Sir Robert Francis QC. The key elements are:</p> <ul style="list-style-type: none"> • duty of candour; • safe care and avoidable harm; • staff guidance, and; • a patient-centred NHS.
6	<p>The handbook of the NHS Constitution should be revised to include a much more prominent reference to the NHS values and their significance.</p>	<p>Accepted.</p> <p>The Department of Health has already taken action to reflect this recommendation in the <i>Handbook to the NHS Constitution</i>.</p> <p>As noted in the response to recommendation 4, the <i>NHS Constitution</i> sets out the following values for the NHS:</p> <ul style="list-style-type: none"> • Working together for patients • Respect and dignity 	<p>Sir Robert Francis QC was clear in his Inquiry report that the principal message of the NHS Constitution should be that patients and their safety come first. In <i>Hard Truths</i>, the Department of Health committed to strengthening the NHS Constitution to make this clearer for patients, staff and the public. To this end, The Government has launched a consultation into, amongst other things, refreshing the NHS Constitution to reflect the recommendations made by Sir Robert Francis QC. The key elements are:</p> <ul style="list-style-type: none"> • duty of candour; • safe care and avoidable harm; • staff guidance, and; • a patient-centred NHS.

		<ul style="list-style-type: none"> • Commitment to quality of care • Compassion • Improving lives • Everyone counts. <p>The Constitution provides more information about these values, and the Department included an explanation of these values in the handbook when it was updated in March 2013.</p>	
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.	<p>Accepted in principle.</p> <p>It is important that employers are able to recruit and retain the caring and compassionate staff the NHS needs. NHS Employers will support NHS organisations in developing and strengthening local policies and guidance so that there is a clear link between the values in the NHS Constitution and their own local values.</p> <p>The Department of Health will commission NHS Employers to support NHS organisations in strengthening local policies on appraisal and performance management are strengthened so that there is a clear line of sight between the NHS values, the Constitution and performance and appraisal systems.</p> <p>Steps have already been taken to improve performance and appraisal systems and agreement has been reached that, with effect from March 2013, pay progression will be linked more strongly to performance for the 1.1 million staff on Agenda for Change pay, terms and conditions. The agreement makes clear that:</p> <ul style="list-style-type: none"> • Employers must reference the NHS Constitution in local performance arrangements; • Knowledge and experience are not the <i>only</i> factors which employers should consider when they develop local performance standards; • Employers now have the flexibility to consider not only what staff do for patients, but how they care for patients, encouraging the right behaviours and values. <p>Staff appraisal is a critical part of staff performance and should be used to hold staff to account on how their behaviour demonstrates the values of the NHS and/or their organisation. The evidence shows that where staff performance is regularly and effectively reviewed, outcomes for patients are better.</p>	<p>Sir Robert Francis QC was clear in his Inquiry report that the principal message of the NHS Constitution should be that patients and their safety come first. In <i>Hard Truths</i>, the Department of Health committed to strengthening the NHS Constitution to make this clearer for patients, staff and the public. To this end, The Government has launched a consultation into, amongst other things, refreshing the NHS Constitution to reflect the recommendations made by Sir Robert Francis QC. The key elements are:</p> <ul style="list-style-type: none"> • duty of candour; • safe care and avoidable harm; • staff guidance, and; • a patient-centred NHS.
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.	<p>Accepted.</p> <p>The NHS Standard Contract requires all providers to have regard to the <u>NHS Constitution</u>. NHS England will strengthen this requirement in respect of subcontractors in future.</p> <p>The care patients receive should reflect NHS core values, as outlined in the Constitution, regardless of whether staff have been externally contracted. NHS commissioners are committed to ensuring core values permeate provider organisations and the wider system.</p> <p>By December 2013, NHS England will amend the NHS Standard Contract for 2014–15 to require providers to ensure their subcontractors fully understand, and abide by, the importance of the Constitution.</p> <p>NHS England will also include an equivalent requirement in November 2013 in</p>	<p>NHS England published the <u>NHS Standard Contract for 2014–15</u> in December 2013. In line with recommendation 8, the provisions of the NHS Standard Contract were revised to strengthen the requirements on all providers of commissioned healthcare services (other than primary care), including all staff and all sub-contractors, to abide by the <u>NHS Constitution</u>. The specific wording of the 2014/15 NHS Standard Contract now reads (Service Condition 1.3): “The Parties must abide by and promote awareness of the NHS Constitution, including the rights and pledges set out in it. The Provider must ensure that all Sub-Contractors and all Staff abide by the NHS Constitution”.</p>

		standard contracts for commissioning support services. This will ensure the values outlined in the Constitution extend beyond providers of services through the wider system.	
9	The NHS Constitution should include reference to all the professional and managerial codes by which NHS staff are bound, including the Code of Conduct for NHS Managers.	<p>Accepted in principle.</p> <p>We support the principle of making clear which codes staff are expected to follow. However, as the <i>NHS Constitution</i> is intended to be a succinct and enduring document, the details of codes are more appropriately set out in the <i>Handbook to the NHS Constitution</i> rather than the Constitution.</p> <p>The Constitution already includes a duty for staff <i>'to accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role'</i>. The handbook, which provides more detailed guidance on each of the rights, pledges and responsibilities included in the Constitution, sets out the relevant professional bodies but does not currently reference the relevant codes of these bodies nor any managerial codes.</p> <p>When the Constitution is next updated, the Department of Health will consider how best to reflect in the Handbook the codes of conduct including the relevant professional and managerial codes, by which NHS staff are bound at that time.</p>	<p>Sir Robert Francis QC was clear in his Inquiry report that the principal message of the NHS Constitution should be that patients and their safety come first. In <i>Hard Truths</i>, the Department of Health committed to strengthening the NHS Constitution to make this clearer for patients, staff and the public. To this end, The Government has launched a consultation into, amongst other things, refreshing the NHS Constitution to reflect the recommendations made by Sir Robert Francis QC. These are:</p> <ul style="list-style-type: none"> • duty of candour; • safe care and avoidable harm; • staff guidance, and; • a patient-centred NHS.
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.	<p>Accepted in principle.</p> <p>The <i>NHS Constitution</i> already sets out a legal duty for staff <i>'to accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role'</i>. This includes having regard to the relevant guidance or regulations of their regulatory bodies, and applies to staff in regulated professions. However, the Constitution does not include an expectation that all staff (whether in a regulated profession or not) should follow guidance and standards relevant to their work, nor does the existing provision in the Constitution encompass standards and guidance produced by non-regulatory organisations to which staff may be expected to have regard.</p> <p>When the Constitution is next updated, the Department of Health will therefore consult on how best to reflect an expectation that staff will have regard to guidance, standards and codes that are relevant to their role. The Department will also consider how to reflect this issue in the <i>Handbook to the NHS Constitution</i>.</p>	<p>Sir Robert Francis QC was clear in his Inquiry report that the principal message of the NHS Constitution should be that patients and their safety come first. In <i>Hard Truths</i>, the Department of Health committed to strengthening the NHS Constitution to make this clearer for patients, staff and the public. To this end, The Government has launched a consultation into, amongst other things, refreshing the NHS Constitution to reflect the recommendations made by Sir Robert Francis QC. These are:</p> <ul style="list-style-type: none"> • duty of candour; • safe care and avoidable harm; • staff guidance, and; • a patient-centred NHS.
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 disagreement 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.	<p>Accepted.</p> <p>Where there is good evidence that standardised procedures minimise risk and promote safer care, then it is the responsibility of healthcare staff to comply with these.</p> <p>The Department of Health is drawing up a new set of fundamental standards of care that will sit within the legal requirements that providers of health and adult social care must meet to be registered with the Care Quality Commission. Fundamentals of care will be set out in regulations, supplemented by guidance about compliance developed by the Care Quality Commission, and will also signpost guidance produced by the National Institute for Health and Care Excellence and others. Many of the fundamental standards of care will include human rights dimensions, for example, they will (subject to Parliamentary approval) confer on providers a duty to, among other things, treat people with dignity and respect, protect them from abuse, involve them in their care,</p>	<p>The Government has passed legislation that will put in place new fundamental standards as requirements for registration with the Care Quality Commission. These fundamental standards set the level below which care must not fall. Where providers fail to meet these standards the Care Quality Commission will be able to use its enforcement powers to protect patients and service users from the risks of poor care – including prosecuting providers where a failure to meet a fundamental standard results in avoidable harm to a patient or service user, or a significant risk of such harm.</p> <p>The fundamental standards will come into force for all providers registered with the Care Quality Commission in April 2015. Two new regulations introducing a duty of candour for NHS bodies and a fit and proper person requirement for directors of NHS bodies came into force in November 2014.</p>

		<p>and look after their care and welfare. The fact that fundamental standards of care will cover issues also protected by human rights mean that patients and other service users will have additional protection to that which already exists under the Human Rights Act 1998 and equality legislation.</p> <p>NHS England has agreed with the National Institute for Health and Care Excellence that the Inquiry's concept of enhanced standards will be in the form of the existing quality standards, which are developed by National Institute for Health and Care Excellence and endorsed by NHS England. Commissioners will be expected to ensure compliance with these.</p> <p>In terms of input by professional bodies, the Academy of Royal Medical Colleges and Faculties have always taken an active leadership role in setting clinical service delivery standards. The Academy of Royal Medical Colleges and Faculties is working with the Care Quality Commission and the National Institute for Health and Care Excellence on how professional bodies will contribute to the development of standards and compliance measures and through this work, the Academy of Royal Medical Colleges and Faculties will make a significant contribution to consistency of patient experience, patient safety and clinical efficiency.</p>	<p>In July 2014, Care Quality Commission consulted providers, health care professionals and other key stakeholders on proposed guidance on meeting the new regulations. The Care Quality Commission has published final guidance on how organisations may comply with the duty of candour and the fit and proper person requirement for NHS bodies which came into force in November 2014.</p> <p>The Care Quality Commission has also recently published a series of provider handbooks. These will sit alongside the guidance on the regulations and describe the end to end inspection process, including how the Care Quality Commission will judge what good quality care looks like and how the Care Quality Commission will rate providers. The handbooks cover <u>hospitals</u>, <u>specialist mental health services</u>, <u>community health services</u>, <u>adult social care</u>, and <u>GP and out of hours services</u>.</p> <p>The Care Quality Commission has been working with healthcare professionals including the Royal Colleges and their faculties, as well as providers, the public and other stakeholders throughout the development of its new regulatory approach. This has included:</p> <ul style="list-style-type: none"> • engagement in the development of the Care Quality Commission's new approach to monitoring, inspecting and rating services and guidance on new regulations and enforcement powers; • identification of healthcare professionals to participate in the Care Quality Commission's inspections; • support for the Care Quality Commission's work on the use of clinical service accreditation schemes; • commitment to working together through the development of memoranda of understanding, joint working statements and information sharing agreements.
12	<p>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.</p>	<p>Accepted.</p> <p>The Government agreed in its response to the Inquiry, <i>Patients First and Foremost</i>, that clear accountability for Trust Boards is essential so that they understand their responsibilities to patients. This includes a regard to patient safety and fundamental standards.</p> <p>The Care Quality Commission will develop and inspect against the fundamental standards, of which patient safety will be an essential component. NHS England is committed to working with the Care Quality Commission on developing a shared and agreed approach to measuring safety in the NHS (both for regulatory and improvement purposes) and is actively in discussion with the Care Quality Commission on the patient safety measures, including incident reporting, best suited for use in their surveillance model and how NHS England can contribute to this.</p> <p>'Patient safety incidents reported' is also one of the overarching indicators in Domain 5 of the NHS Outcomes Framework and describes the readiness of the NHS to report harm and learn from it. Therefore, it is important that staff receive feedback on any concerns they raise about patient safety including via local incident reporting systems. At a national level, NHS England will re-commission the National Reporting and Learning System to improve its functionality, users and benefits. This will also aim to strengthen reporting and learning from the most serious incidents, with quicker notification and feedback of the relevant lessons learnt, and with more efficient mechanisms for distributing incident reports to relevant organisations, such as clinical commissioning groups, the Care Quality Commission, Monitor, the National Trust Development Authority and the Medicines and Healthcare products Regulatory</p>	<p>Patient safety incident reporting is a key part of patient safety improvement. Patient safety incident reporting to the National Reporting and Learning System continues to increase year on year. Data published in April 2014 showed that in the six months from April 2013 to September 2013, 725,314 incidents in England were reported to the National Reporting and Learning System, 8.9% more than in the same period in the previous year.</p> <p>On 24 June, NHS England published the results of a new indicator on the NHS Choices website, rating NHS hospitals for their incident reporting. A good reporting culture in an organisation means that the organisation reports patient safety incidents frequently, reports the more serious incidents that occur but also reports many incidents involving low and no harm to patients, because its staff understand that by reporting even these less serious incidents, the organisation can learn and improve. A good reporting culture is also indicated by the staff of a hospital saying they think the organisation has fair and effective procedures when incidents are reported. These aspects of incident reporting have been combined from existing data sources, including the Care Quality Commission Intelligent Monitoring data, to give a composite rating for each acute hospital's reporting culture. The rating does not describe whether a hospital is safe, but does provide patients with authoritative and easy to access information on how well developed the organisation's patient safety incident reporting culture is and will encourage organisations to improve their reporting culture.</p> <p>Work to re-commission the National Reporting and Learning System has been progressed by NHS England with the development of a long list of options for the new system based on input from a wide range of stakeholders and experts. The options are now being appraised in terms of technical feasibility, deliverability</p>

		<p>Agency.</p>	<p>and operational impact and will be utilised to support the strategic business case. The procurement of the new system will then progress in the 2015/16 financial year, subject to approvals.</p> <p>The Care Quality Commission is giving greater prominence to safety alerts in its revised surveillance model. The Care Quality Commission's NHS acute Intelligent Monitoring system includes a composite indicator around completion of safety alerts which contributes to providers' risk scores. Discussions are taking place as to whether this can be implemented for the other sectors the Care Quality Commission regulates.</p> <p>Providers are expected to retain accountability for implementing patient safety alerts while demonstrating safety improvement and learning in order to give safety alerts more prominence in the inspection model.</p>
13	<p>Standards should be divided into:</p> <ul style="list-style-type: none"> • 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. • Enhance 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. 	<p>Accepted.</p> <p>The Department of Health, the National Institute for Health and Care Excellence, NHS England and the Care Quality Commission are working on a new framework of standards. New regulations setting out fundamental standards of care will come into effect during 2014, and will apply to all providers of health and social care required to register with the Care Quality Commission. Through its Chief Inspectors, the Care Quality Commission is engaging with providers, professionals and the public on what guidance it should publish on complying with these regulations and how they should relate to the Care Quality Commission's broader assessments of the quality of health and care services.</p> <p>In <i>Patients First and Foremost</i> the Government confirmed that the Care Quality Commission would work with stakeholders to draw up a set of simpler fundamental standards that would make explicit the basic standards, and set a clear bar below which care should never fall. In June 2013, the Care Quality Commission issued <i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i>. This document started the public discussion on what the fundamental standards of care should be. On 17 October 2013, the Care Quality Commission published the responses to the consultation in <i>A new start: Responses to our consultation on changes to the way the Care Quality Commission regulates, inspects and monitors care services</i>, which showed that there is broad agreement with the new approach. The Department will consult shortly on the draft regulations; these will set in legislation the fundamental standards of care as outcomes that providers must meet. The final set of standards is likely to cover areas such as: care and safety of patients and service users; abuse, including neglect; respecting and involving service users; nutrition; consent; governance; cleanliness and safety of premises and equipment; staffing; fitness of directors; and duty of candour.</p> <p>The Care Quality Commission will issue succinct guidance on meeting the regulations' requirements, which it will take into account when considering prosecutions. This guidance will sit alongside the broader handbook that the Care Quality Commission will issue on how it decides ratings of providers and services.</p> <p>The fundamental standards of care will be part of the regulatory system in their own right, alongside the Care Quality Commission's broader assessments of the overall quality of a provider's services. This will start initially in the hospital sector, but also alongside new Chief Inspectors of General Practice and Adult Social Care, who will extend and develop the approach for their respective sectors over time. The Care Quality Commission will keep guidance for their sectors under review and will advise Ministers if changes to the regulations are needed.</p> <p>The National Institute for Health and Care Excellence has an existing programme of production of quality standards that define what high quality care should look like in a defined care or service area. Topics in healthcare are referred by NHS England to the</p>	<p>The National Institute for Health and Care Excellence has introduced developmental statements in its quality standards where appropriate. Between June and September 2014 it published <i>NICE quality standards - the process guide</i> a consultation on its updated quality standards process guide which made detailed proposals for how developmental statements would be identified and produced.</p> <p>The Government has passed legislation that will put in place new fundamental standards as requirements for registration with the Care Quality Commission. These fundamental standards set a minimum level below which care must not fall. Where providers fail to meet these standards the Care Quality Commission will be able to use its enforcement powers to protect patients and service users from the risks of poor care – including prosecuting providers where a failure to meet a fundamental standard results in avoidable harm to a patient or service user, or a significant risk of such harm.</p> <p>The fundamental standards will come into force for all providers registered with the Care Quality Commission in April 2015. Two new regulations introducing a duty of candour for NHS bodies and a fit and proper person requirement for directors of NHS bodies came in to force in November 2014. The Care Quality Commission published guidance for providers on the duty of candour for NHS bodies and the fit and proper person requirement for directors of NHS bodies regulations to help providers meet the requirements of the regulations.</p> <p>The Care Quality Commission has also recently published a series of provider handbooks. These will sit alongside the guidance on the regulations and describe the end to end inspection process, including how the Care Quality Commission will judge what good quality care looks like and how the Care Quality Commission will rate providers. The handbooks cover <u>hospitals</u>, <u>specialist mental health services</u>, <u>community health services</u>, <u>adult social care</u>, and <u>GP and out of hours services</u>.</p>

		<p>National Institute for Health and Care Excellence, and the National Institute for Health and Care Excellence provides guidance for commissioners to help them to commission for quality improvement within these areas. Enhanced quality standards are set out for commissioners in the National Institute for Health and Care Excellence quality standards, which in future will also specify developmental standards.</p>	
14	<p>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.</p>	<p>Accepted in principle.</p> <p>The Department of Health will consult on regulations which introduce fundamental standards of care and a clearer focus on governance arrangements for complying with them. These will be reflected in the Care Quality Commission's new approach to inspection. The Care Quality Commission has powers to access any information that it deems necessary to carry out its functions, and through its checks on governance (including information governance), can assure that hospitals provide it with accurate information on how they are providing care that is safe, effective, caring, responsive and well-led. However, in order that the public can find information in one place, it is the Care Quality Commission rather than each provider that should publish information about providers' performance, which it will do via ratings. Placing this information with the Care Quality Commission will allow the public to make informed comparisons and decisions about the care provider they choose. The Care Quality Commission's ratings will report on overall quality, which will be broader than fundamental and enhanced standards.</p> <p>The Care Quality Commission consulted over summer 2013 on what should be considered fundamental standards of care. The Department will consult on regulations which will set these fundamental standards in legislation. The final set of standards is likely to cover areas such as: care and safety of patients and service users; abuse, including neglect; respecting and involving service users; nutrition; consent; governance; cleanliness and safety of premises and equipment; staffing; fitness of directors; and duty of candour. In parallel with the Department's consultation on the regulations, the Care Quality Commission will consult on statutory guidance that it will take into account in enforcement, including prosecution, and issue a handbook to provide clarity on how it awards ratings. The regulations should come into force during 2014 and will also streamline and make clearer other requirements on providers, including governance arrangements for complying with fundamental standards.</p> <p>The Care Quality Commission started implementing its new approach to hospital inspection in September 2013. The approach is based around judging five dimensions of quality, one of which is how well-led a service is. This includes the governance and leadership of culture of the service. In December 2013 the Care Quality Commission will set out information in more detail in guidance, so that there is transparency in how it will rate acute hospitals. This will build on the proposals in <u><i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i></u> by providing more detail on:</p> <ul style="list-style-type: none"> • what the five questions that the Care Quality Commission inspects* will cover • the definition of each level of the rating scale (outstanding, good, requires improvement inadequate) • key lines of enquiry that will always be followed to ensure consistent ratings • indicators and data that contribute to the rating, and any methods or rules for aggregating them • how judgements are made from inspection findings and data, to place a provider in a ratings band. 	<p>New Fundamental Standards regulations come into force for all providers of health and social care in April 2015. The fundamental standards are:</p> <ul style="list-style-type: none"> • care and treatment must be appropriate and reflect service users' needs and preferences. • service users must be treated with dignity and respect. • care and treatment must only be provided with consent. • care and treatment must be provided in a safe way. • service users must be protected from abuse and improper treatment. • service users' nutritional and hydration needs must be met. • all premises and equipment used must be clean, secure, suitable and used properly. • complaints must be appropriately investigated and appropriate action taken in response. • systems and processes must be established to ensure compliance with the fundamental standards (good governance). • sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed. • persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed. • A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity (Duty of Candour). <p>Under the leadership of the Chief Inspector of Hospitals, the Care Quality Commission started piloting its new inspection model in 18 acute trusts in September 2013. A summary of the findings from these inspections was published by March 2014. Since April 2014 all acute NHS trusts inspections have used the new methodology. By December 2015, the Care Quality Commission will have inspected all NHS Hospitals using its new methodology.</p> <p>In January 2014, the Care Quality Commission began testing its new inspection model in mental health, community services and NHS general practice out of hour's services. In April 2014, the first new-style inspections started in 200 general practices and in adult social care. Between April and June 2014, the Care Quality Commission consulted on how it planned to change the way it regulates, inspects and rate care services. The resulting changes come into effect in April 2015 and <u>consultation handbooks</u> were issued for the seven types of provider: acute, mental health and community hospitals; NHS GP and out of hours services; residential, community and hospice adult social care services. The handbooks set out for each type of provider:</p> <ul style="list-style-type: none"> • what the Care Quality Commission look at on an inspection. • how the Care Quality Commission judge what 'good' care looks like. • how the Care Quality Commission rate care services to help people judge and choose care if they want to. • how the Care Quality Commission use information to help decide when and where to inspect. <p>From April 2014, the Care Quality Commission began rating hospitals' quality of care in bands ranging from outstanding to inadequate. The full roll out of ratings</p>

		<p>New Chief Inspectors of General Practice and Adult Social Care took up post at the Care Quality Commission in October 2013. They will spearhead the extension and development of the new inspection approach that has started in hospitals, to their respective sectors, and together will ensure that the Care Quality Commission is providing assurance that health and adult social care services join up seamlessly from the perspective of people who use services. The Deputy Chief Inspector of Mental Health will report to the Chief Inspector of Hospitals on how this applies to mental health services.</p> <p>*Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well-led?</p>	<p>for hospitals, and ratings for social care and GPs began to be used from October 2014. Ratings give patients and the public a fair, balanced and easy to understand assessment of how well a provider is performing.</p>
15	<p>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.</p>	<p>Accepted in principle.</p> <p>The Department of Health will consult on new regulations which introduce fundamental standards of care and a clearer focus on governance arrangements for complying with them. The Care Quality Commission will consult on and issue guidance for providers, which will cover all elements of governance covered by the new regulations. Subject to consultation and Parliament, the regulations will be put in place during 2014 and then implemented progressively in all sectors.</p> <p>In June 2013, the Care Quality Commission issued <u><i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i></u>. This set out proposals to assess providers and services with regard to five key questions, one of which is whether the service is well-led. Being well-led particularly concerns the culture, leadership and governance of the service and the provider. On 17 October 2013, the Care Quality Commission published the responses to the consultation in <u><i>A new start: Responses to our consultation on changes to the way the Care Quality Commission regulates, inspects and monitors care services</i></u>, which showed that there is broad agreement with the new approach.</p> <p>The Care Quality Commission has introduced a new approach to inspection, including making judgements on five dimensions of quality*, one of which is how well-led a service is. This includes the effectiveness and existence of governance systems. The Care Quality Commission is working with Monitor, the NHS Trust Development Authority and NHS England to ensure that there is a single, coherent approach to oversight of governance. This will result in a single aligned framework for monitoring governance, coherent across all the elements of governance which are covered variously by the Care Quality Commission, NHS Trust Development Authority, Monitor or NHS England's areas of responsibility.</p> <p>*Is the service safe? Is the service effective? Is the service caring? Is the service responsive to people? Is the service well-led?</p>	<p>Between January and April 2014, the Department of Health consulted on new Fundamental Standards regulations. These have been approved by Parliament and will come into force for all providers of health and social care in April 2015. The <u>consultation response</u> was published in July 2014.</p> <p>To meet the fundamental standard for good governance, providers must have oversight of planning, delivery and monitoring of all care and treatment. It must know what action is taken to mitigate risks to the quality and safety of care and treatment, and what action is taken in response to issues raised by monitoring activities. This includes ensuring that it has access to all relevant information about its service(s), including information about the experience of service users and others. The provider must also take timely and appropriate corrective action where there is a risk of a regulatory breach occurring, or where a regulatory breach has occurred. Additionally, the provider must securely maintain appropriate and accurate records as follows:</p> <ul style="list-style-type: none"> • Records about all aspects of the care and treatment of each service user. • Relevant records about persons it employs for designing and delivering care and treatment. • Any other records which may be appropriate for managing the carrying on of regulated activities. <p>The provider must also continually evaluate and make improvements to the systems and processes that are used to achieve the above. Information on the new inspection model programme and the Care Quality Commission consultation is given under recommendation 14.</p>
16	<p>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.</p>	<p>Accepted.</p> <p>The Department of Health will shortly consult on new regulations that will provide for fundamental standards of care. The final set of standards is likely to cover areas such as: care and safety of patients and service users; abuse, including neglect; respecting and involving service users; nutrition; consent; governance; cleanliness and safety of premises and equipment; staffing; fitness of directors; and duty of candour. The consultation will include engagement events with professionals and the public to ensure that a wide a spectrum of views is collected. Subject to Parliament, these will come into force during 2014.</p> <p>In <u><i>Patients First and Foremost</i></u> the Government confirmed that the Care Quality Commission would work with stakeholders to draw up a set of simpler fundamental</p>	<p>Between January and April 2014, the Department of Health consulted on new fundamental standards regulations. The Care Act 2014 received Royal Assent in May 2014 and these will come into force for all providers of health and social care in April 2015. The <u>consultation response</u> was published in July 2014.</p> <p>New Fundamental Standards regulations come into force for all providers of health and social care in April 2015. The fundamental standards are:</p> <ul style="list-style-type: none"> • care and treatment must be appropriate and reflect service users' needs and preferences. • service users must be treated with dignity and respect. • care and treatment must only be provided with consent. • care and treatment must be provided in a safe way.

		<p>standards to make explicit the basic standards and set a clear bar below which care should never fall. In June 2013, the Care Quality Commission issued <u><i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care.</i></u> This document started the public discussion on what the fundamental standards of care should be. The consultation engaged 5,154 individuals and 4,500 organisations, plus 41 consultation events. Respondees included the medical and nursing Royal Colleges and the Nursing and Midwifery Council. The professional bodies were also part of a stakeholder advisory group with the Care Quality Commission. On 17 October 2013, the Care Quality Commission published the responses to the consultation in <u><i>A new start: Responses to our consultation on changes to the way the Care Quality Commission regulates, inspects and monitors care services,</i></u> which showed that there is broad agreement with the new approach. The Department is using the responses to this consultation to develop its new draft regulations.</p> <p>Through the Chief Inspector of Hospitals, the Care Quality Commission will consult on guidance for hospital providers on how they should comply with the requirements in the regulations. In December 2013 the Care Quality Commission will set out information in more detail in guidance, so that there is transparency in how it will rate acute hospitals. This will build on the proposals in <u><i>A new start</i></u> by providing more detail on:</p> <ul style="list-style-type: none"> • what the five questions that the Care Quality Commission inspects* will cover • the definition of each level of the rating scale (outstanding, good, requires improvement inadequate) • key lines of enquiry that will always be followed to ensure consistent ratings • indicators and data that contribute to the rating, and any methods or rules for aggregating them • how judgements are made from inspection findings and data, to place a provider in a ratings band. <p>While the focus is on hospital services in the first instance, new Chief Inspectors of General Practice and Adult Social Care, who took up post in the Care Quality Commission in October 2013, will extend and develop guidance on the regulations for providers in their respective sectors. The Deputy Chief Inspector of Mental Health will report to the Chief Inspector of Hospitals on how this applies to mental health services. Together they will ensure that the Care Quality Commission is providing assurance that health and adult social care services join up seamlessly from the perspective of people who use services.</p> <p>*Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well-led?</p>	<ul style="list-style-type: none"> • service users must be protected from abuse and improper treatment. • service users' nutritional and hydration needs must be met. • all premises and equipment used must be clean, secure, suitable and used properly. • complaints must be appropriately investigated and appropriate action taken in response. • systems and processes must be established to ensure compliance with the fundamental standards (good governance). • sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed. • persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed. • A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity (Duty of Candour). <p>In July 2014, the Care Quality Commission published a <u>consultation</u> on guidance for providers meeting the fundamental standards and on the Care Quality Commission's enforcement powers. The consultation closed on 17 October 2014. The Care Quality Commission is considering the responses and will publish its new guidance prior to April 2015.</p> <p>To meet the fundamental standard for good governance, providers must have oversight of planning, delivery and monitoring of all care and treatment. It must know what action is taken to mitigate risks to the quality and safety of care and treatment, and what action is taken in response to issues raised by monitoring activities. This includes ensuring that it has access to all relevant information about its service(s), including information about the experience of service users and others. The provider must also take timely and appropriate corrective action where there is a risk of a regulatory breach occurring, or where a regulatory breach has occurred. Additionally, the provider must securely maintain appropriate and accurate records as follows:</p> <ul style="list-style-type: none"> • Records about all aspects of the care and treatment of each service user. • Relevant records about persons it employs for designing and delivering care and treatment. • Any other records which may be appropriate for managing the carrying on of regulated activities. <p>The provider must also continually evaluate and make improvements to the systems and processes that are used to achieve the above. The three Chief Inspectors will use the insights of people who use services to guide, inform and influence the inspection process and the judgements that come out of it. Information on the new inspection model programme and the Care Quality Commission consultation are given under recommendation 14.</p> <p>From April 2014, the Care Quality Commission began rating hospitals' quality of care in bands ranging from outstanding to inadequate. The full roll out of ratings for hospitals, and ratings for social care and GPs began to be used from October 2014. Ratings give patients and the public a fair, balanced and easy to understand assessment of how well a provider is performing. Ratings will give patients and the public a fair, balanced and easy to understand assessment of how well a provider is performing.</p>
17	The NHS Commissioning Board together with clinical commissioning groups should	Accepted in principle.	The National Institute for Health and Care Excellence has introduced developmental statements in its quality standards where appropriate. Between

	<p>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.</p>	<p>NHS England and clinical commissioning groups will have regard to enhanced quality standards in the way they commission services, and the Care Quality Commission will use them to inform their ratings of providers.</p> <p>NHS England will work with clinical commissioning groups to use enhanced quality standards to drive improvements in the health service. NHS England has agreed with the National Institute for Health and Care Excellence that the concept of enhanced standards is represented by the existing quality standards, developed by National Institute for Health and Care Excellence and endorsed by NHS England. Compliance with these standards should indeed be a matter for commissioners rather than the regulator. NHS England is currently required in legislation to have regard to quality standards, and clinical commissioning groups are required to do the same through NHS England's planning guidance.</p> <p>The Care Quality Commission will use enhanced quality standards to inform its quality ratings of providers. In line with recommendation 13, where there are emergent evidence-based technologies with the potential to drive widespread improvements, the National Institute for Health and Care Excellence will also include developmental standards within quality standards.</p> <p>As outlined in the response to recommendation 249, providers are required to publish a Quality Account each year, providing accurate information on their performance in relation to quality standards. NHS England will review Quality Accounts before the 2014-15 cycle to ensure that they give patients appropriate information on the services they use, and that they add value to the quality assurance infrastructure used by trusts, local and national organisations.</p>	<p>June and September 2014 it published <i>the National Institute for Health and Care Excellence quality standards - the process guide</i>, a consultation on its updated quality standards process guide which made detailed proposals for how developmental statements would be identified and produced.</p> <p>The Care Quality Commission and Monitor work together to assess the capability of a Foundation Trust and/or its leadership to ensure safe and quality care. Monitor makes this assessment from the Board down, the Care Quality Commission from the ward up. The Care Quality Commission and Monitor have a new single, overarching framework for judging whether or not an organisation and/or service are well-led. The Care Quality Commission and Monitor use the framework to help inform their assessments and inspections.</p> <p>The framework is used during the routine inspection of Foundation Trusts where the Care Quality Commission requests information from Monitor in preparation for an inspection. The Care Quality Commission's inspection provides a judgement on the quality of services and Monitor will then take action where necessary to support improvement. The Chief Inspector of Hospitals can also recommend that a Foundation Trust be put in special measures. As part of this, Monitor provides intensive support, including appointing an Improvement Director. The Care Quality Commission will then re-inspect and recommend whether the Foundation Trust should be kept in, or taken out of, special measures.</p> <p>For example in July 2013, after the Care Quality Commission inspection identified significant concerns about the quality of care, the Chief Inspector of Hospitals recommended that North Lincolnshire & Goole NHS Foundation Trust be placed in special measures. Monitor initially used its powers to agree a programme of work with the Foundation Trust to address issues in governance, clinical effectiveness, patient safety and experience. Monitor subsequently oversaw the Foundation Trust's delivery of this programme, resulting in the quality issues being addressed. Following a recommendation from the Chief Inspector, the Foundation Trust was removed from special measures in July 2014.</p> <p>The Care Quality Commission, Monitor and the NHS Trust Development Authority have jointly developed and published guidance on how the special measures programme worked for NHS trusts and Foundation Trusts. The Care Quality Commission and Monitor have also published a <u>joint working agreement document</u> setting out how they will work together.</p> <p>A review of Quality Accounts has taken place in 2013/14 and engaged 180 stakeholders, including patients, carers, service providers, Healthwatch, NHS England, NHS Trust Development Authority, Care Quality Commission and Monitor. As a result of this review, there is now an area on NHS Choices providing presentational guidance and as part of the review, it was recommended this should be further developed to include guidance about publishing data in a more patient friendly way. This will be further developed in 2014/15. The Quality Accounts review also identified the need to provide local Healthwatch organisations with guidance on how to effectively challenge local Quality Accounts. This is being taken forward by NHS England and Healthwatch with a view that this will help to inform the approach Healthwatch take to commenting on Quality Accounts in 2014/15.</p>
18	<p>It is essential that professional bodies in which doctors and nurses have confidence are fully involved in the formulation and in the means of measuring compliance.</p>	<p>Accepted.</p> <p>The Care Quality Commission is taking steps to ensure that stakeholders, particularly including professional bodies, are fully involved in designing and developing its new approach to inspection. The Care Quality Commission's new</p>	<p>All of the Care Quality Commission's new style inspections involve healthcare professionals as part of the inspection teams, according to their areas of specialism and training and depending on the service being inspected. In addition to this many of the Care Quality Commission's inspectors themselves</p>

		<p>approach to inspecting hospitals involves large teams of specialists as well as patient experts. The Care Quality Commission is working with medical and nursing Royal Colleges to resource the inspection teams. These teams give professionals a key role in how a hospital's quality of care is assessed.</p> <p>The Care Quality Commission has consulted extensively on its new approach to inspection. The consultation engaged 5,154 individuals and 4,500 organisations, plus 41 consultation events. Professional bodies, and individual professionals, have been prominent contributors to these. On 17 October 2013, the Care Quality Commission published the responses to the consultation in, <i><u>A new start: Responses to our consultation on changes to the way the Care Quality Commission regulates, inspects and monitors care services</u></i> which showed that there is broad agreement with the new approach.</p> <p>The Care Quality Commission is undertaking further work to deepen the engagement of professional bodies in developing its new approach, and in particular medical, nursing and midwifery Royal Colleges. Memoranda of understanding are in development with all of these bodies, covering collaboration in:</p> <ul style="list-style-type: none"> •resourcing inspection teams; •developing standards and expectations of 'what good looks like' in different services; and •recognising accreditation schemes where that can encourage achievement of best practice standards and avoid duplicated inspection. 	<p>come from specialist health backgrounds and are working in the sector in which they trained. For example, the Care Quality Commission inspectors who are clinical scientists and radiographers by training inspect radiology facilities and departments, both as individual inspections and as part of broader hospital inspections, providing specialist insight. The Care Quality Commission's Chief Inspectors of Hospitals, Adult Social Care and General Practice themselves have significant experience and expertise in their sectors, as well as a number of their Deputy Chief Inspectors.</p> <p>The Care Quality Commission has been working with healthcare professionals including the Royal Colleges and their faculties, as well as providers, the public and other stakeholders throughout the development of its new regulatory approach. This has included:</p> <ul style="list-style-type: none"> • Engagement in the development of the Care Quality Commission's new approach to monitoring, inspecting and rating services and guidance on new regulations and enforcement powers • Identification of healthcare professionals to participate in the Care Quality Commission's inspections • Support for the Care Quality Commission's work on the use of clinical service accreditation schemes • Commitment to working together through the development of memoranda of understanding, joint working statements and information sharing agreements <p><u>Joint agreements</u></p> <p>The Care Quality Commission works with strategic partner organisations including healthcare professional bodies in the development and delivery of its regulatory activity. These partnerships are underpinned by the development of joint agreements which set out:</p> <ul style="list-style-type: none"> • clear expectations and objectives for the relationships • a framework for information exchange and operational working • clear evaluation criteria • a public signal of intent to work together
19	<p>There should be a single regulator dealing with both corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts.</p>	<p>Not accepted, although we agree with the principle of a single regulatory process.</p> <p>We agree with the principle that there should be a single regulatory process with clearly defined responsibilities across governance, finance and compliance with safety and quality standards. It is important that the system is able to identify and act quickly where there are potential risks to service users and, in ensuring this, that there are clear roles and responsibilities for all those involved in that process.</p> <p>In <u>Patients First and Foremost</u> (2013) we stated that the Care Quality Commission, Monitor and the NHS Trust Development Authority would establish a single failure regime that would further clarify the separate functions of the Care Quality Commission and Monitor across health and social care. This will ensure that the role of inspecting Trusts is kept clearly separate from the responsibility for the turnaround of failing organisations, and there can be no conflict of interest in assessing quality. It also allows us to address, more fully, the Inquiry's concerns regarding the potential impact on the whole system of rapid changes to the quality regulator.</p> <p>The Care Bill lays the framework for a simple, flexible process for tackling quality failures in NHS Trusts and Foundation Trusts. It will remain the primary</p>	<p>The Care Quality Commission and Monitor work together to assess the capability of a Foundation Trust and/or its leadership to ensure safe and quality care. Monitor makes this assessment from the Board down, the Care Quality Commission from the ward up. The Care Quality Commission and Monitor have a new single, overarching framework for judging whether or not an organisation and/or service are well-led. The Care Quality Commission and Monitor use the framework to help inform their assessments and inspections.</p> <p>The framework is used during the routine inspection of Foundation Trusts where the Care Quality Commission requests information from Monitor in preparation for an inspection. The Care Quality Commission's inspection provides a judgement on the quality of services and Monitor will then take action where necessary to support improvement. The Chief Inspector of Hospitals can also recommend that a Foundation Trust be put in special measures. As part of this, Monitor provides intensive support, including appointing an Improvement Director. The Care Quality Commission will then re-inspect and recommend whether the Foundation Trust should be kept in, or taken out of, special measures.</p> <p>For example in July 2013, after the Care Quality Commission inspection</p>

		<p>responsibility of the board of a Trust, working with their commissioners, to ensure the provision of good quality care.</p> <p>The Care Quality Commission will not exercise its enforcement powers, beyond issuing a new warning notice outlined in the Care Bill, in respect to Trusts unless patients and service users are at immediate risk of harm, in which case it will be able to act immediately. Where intervention is required it will be the role of Monitor (for Foundation Trusts) and the NHS Trust Development Authority (for NHS trusts) to take action. Ultimately, if it proves impossible for an NHS Trust or Foundation Trust to turn their performance around, the organisation may be placed into Trust special administration on quality grounds. Special administration will provide a framework for determining how best to secure a comprehensive range of high quality services that are both financially and clinically sustainable. In very serious cases, the Care Quality Commission (subject to Parliamentary approval) will have the power to prosecute a provider for a breach of fundamental standards of care.</p> <p>The Care Quality Commission, Monitor and the NHS Trust Development Authority will work together to publish further guidance on how they work together to address risks to quality. This will include details of how concerns, including immediate concerns, will be addressed; how and when special measures and the single failure regime could be triggered; and what guidance and support would be made available to the public in the event of large scale, significant failure. This guidance will build on the joint policy statement, The Regulation and oversight of NHS Trusts and Foundation Trusts (May 2013) published by the Care Quality Commission, Monitor, the NHS Trust Development Authority, NHS England and the Department of Health.</p>	<p>identified significant concerns about the quality of care, the Chief Inspector of Hospitals recommended that North Lincolnshire & Goole NHS Foundation Trust be placed in special measures. Monitor initially used its powers to agree a programme of work with the Foundation Trust to address issues in governance, clinical effectiveness, patient safety and experience. Monitor subsequently oversaw the Foundation Trust's delivery of this programme, resulting in the quality issues being addressed. Following a recommendation from the Chief Inspector, the Foundation Trust was removed from special measures in July 2014.</p> <p>The Care Quality Commission, Monitor and the NHS Trust Development Authority have jointly developed and published guidance on how the special measures programme worked for NHS trusts and Foundation Trusts. The Care Quality Commission and Monitor have also published a joint working agreement document setting out how they will work together.</p>
20	<p>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.</p>	<p>Accepted in part.</p> <p>In June 2013 the Care Quality Commission issued <i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i>. Following this extensive consultation, in September 2013 it carried out its first new-style hospital inspections. The new approach to inspections is based on an overall view of quality and safety, divided into five domains, and includes ratings on each domain as well as overall ratings. This is a substantial change from the previous approach, which focused only on policing compliance with standards. The new-style inspections are underpinned by a published list of indicators, which formed part of the consultation. The inspection approach will include checking providers' governance arrangements, as necessary checking information governance, and the provider's ability to assure its performance information generally. The Care Quality Commission's ratings are also likely to consider specific enhanced standards, as the National Institute for Health and Care Excellence quality standards will be taken into account when awarding a rating, particularly at the 'good' and 'outstanding' levels.</p> <p>However, it would not be appropriate for the Care Quality Commission to be responsible beyond this for regulating the accuracy of information about compliance with enhanced standards. By means of contract management, commissioners will have the specific lead responsibility for holding providers to account for the accuracy of information they provide on performance against enhanced standards. The Care Quality Commission's monitoring will look more broadly at the provider's capability to use information effectively for assurance and improvement, with an expectation that it will disclose relevant information fully and honestly.</p>	<p>The Care Quality Commission will be responsible for policing the fundamental standards when they come into force in April 2015. This will be based on the Care Quality Commission's new approach to inspection. Under the leadership of the Chief Inspectors the Care Quality Commission has put in place specialist inspection teams that subject providers to greater scrutiny. Inspections now routinely involve expert inspectors and people with experience of receiving care.</p> <p>The Care Quality Commission provides regular performance reports to its Board on the quality and safety of health and care services it finds through its inspections. It has also put in place a performance and evaluation programme to assess the impact of its regulatory approach. This is designed to provide:</p> <ul style="list-style-type: none"> • evaluation, analysis and insight on the impact and outcomes of regulation, as viewed and experienced by all stakeholders – providers, people who use services and the public, partners and other stakeholders • evaluation and performance measures in relation to the quality, effectiveness and efficiency of the Care Quality Commission's regulatory approach and delivery • data collection and analysis on the costs of regulation • a framework to analyse and interpret findings, to inform assessment of the Care Quality Commission's value for money.
21	<p>The regulator should have a duty to monitor the accuracy of the information disseminated by providers and commissioners on compliance with standards and their compliance with the requirement of honest disclosure. The regulator</p>	<p>Accepted in principle.</p> <p>The Care Quality Commission already has powers to require information and explanations, with failure to provide these or obstructing an inspector constituting an offence, and has started to put steps in place to improve its monitoring. The Care Quality Commission will not be wholly reliant on one information source; its</p>	<p>The Care Quality Commission has put in place a system of Intelligent Monitoring to help decide when, where and what to inspect. This draws information and data from a range of sources to identify providers and services where there may be a greater risk of providing poor care. The evidence from the Intelligent Monitoring system is used to prioritise which providers will be inspected and the lines of enquiry during an investigation. The system triggers a response, for</p>

	<p>must be willing to consider individual cases of gross failure as well as systemic causes for concern.</p>	<p>new surveillance model, combined with the existing information resources available to it, will allow it to cross- refer concerns and build up a picture of care. It is also a condition of Monitor’s licence that information provided to Monitor is accurate, complete and not misleading. Monitor can and has pursued cases where information provided to it has been inaccurate.</p> <p>The Care Quality Commission has developed a new approach to monitoring hospitals’ performance, which helps direct the timing and focus of inspection. It includes measures of data quality, which may prompt assessment of culture, leadership and governance and, within that, information governance. The Care Quality Commission has a strong key role in that area through its National Information Governance Committee. The Care Quality Commission’s monitoring of hospitals includes a range of systemic indicators, such as outliers on different measures over time), and individual events (examples include reports from whistle blowers, safeguarding incidents, notifiable deaths and incidents). All of these are able to trigger interventions, including inspection.</p> <p>The Care Quality Commission will consider further measures related to data quality as its new system for monitoring providers matures, in order continuously to improve its sensitivity to this aspect of quality of care. Taken together, therefore, the Care Quality Commission already take a range of robust approaches to assessing and verifying the extent to which providers are complying with standards; it is therefore unnecessary to impose a new duty on it.</p>	<p>example, where there are a statistically significant number of severe harm incidents or avoidable deaths at a provider. “Never events” trigger an automated elevated risk in Intelligent Monitoring which inspectors follow up individually. The data it looks at includes information from:</p> <ul style="list-style-type: none"> • Staff • Patient surveys • Mortality rates • Hospital performance information such as waiting times and infection rates <p>In October 2013 the Care Quality Commission began a pilot of its Intelligent Monitoring programme for acute and specialist NHS trusts. The pilot looked at more than 150 different sets of data (indicators), which related to the five key questions the Care Quality Commission asks of all services – are they safe, effective, caring, responsive, and well-led? Using this data, the Care Quality Commission grouped all acute NHS trusts into six priority bands for inspection. In March and July 2014, the Care Quality Commission updated its <u>surveillance model for acute and specialist NHS trusts</u>.</p> <p>In November 2014, the Care Quality Commission published Mental Health Intelligent Monitoring reports, which display the results of its analysis of Tier 1 indicators for all Mental Health NHS trusts. Each trust will receive an individual report and banding, similar to those for acute hospitals. The bandings will range from one to four.</p> <p>In November 2014 the Care Quality Commission published its first round of Intelligent Monitoring for GPs made up of different types of evidence on patient experience, care and treatment, based on sources including surveys and official statistics</p> <p>The Care Quality Commission has always used important information in statutory notifications as an indicator of quality and safety in the adult social care sector, alongside other information about safeguarding alerts and information provided by others such as people who use services, staff and the public. The Care Quality Commission does not have a lot of quantitative data consistently collected across the sector but it is taking steps to improve this. With a new, more thorough model, the Care Quality Commission intends to use all the available information to check whether there is a risk that services do not provide either safe or quality care.</p> <p>Draft Intelligent Monitoring models for the Adult Social Care sector have been in place since October 2014, with separate sets of indicators for residential, community and hospice services. The Care Quality Commission will continue to develop these models with providers and stakeholders to develop a more robust Intelligent Monitoring system within Adult Social Care during 2015/16 and beyond.</p>
22	<p>The National Institute for Health and Clinical Excellence should be commissioned to formulate standard procedures and practice designed to provide the practical means of compliance, and indicators by which compliance with both fundamental and enhanced standards can be measured. These measures should include both outcome and process based measures, and should as far as possible build on information already available within the system or on readily observable behaviour.</p>	<p>Accepted in principle.</p> <p>A range of guidance, indicators and measures will be provided to support the implementation of quality standards. Guidance, technology appraisals and standards provided by the National Institute for Health and Care Excellence make an essential and key contribution to how the Care Quality Commission assesses the quality of NHS services, alongside bodies accredited by the National Institute for Health and Care Excellence and other appropriate sources of guidance and standards. The National Institute for Health and Care Excellence, the Care Quality Commission and NHS England will work together on the objective of ensuring that authoritative guidance is available on fundamental and enhanced standards. The National Institute for Health and Care Excellence already develops indicators to go alongside quality</p>	<p>The National Institute for Health and Care Excellence has introduced developmental statements in its quality standards where appropriate. Between June and September 2014 it published <u>the National Institute for Health and Care Excellence quality standards - the process guide</u>, a consultation on its updated quality standards process guide which made detailed proposals for how developmental statements would be identified and produced.</p> <p>At the end of 2014, the Care Quality Commission and the National Institute for Health and Care Excellence published a Memorandum of Understanding that sets out how the two organisations work in partnership to encourage improvement in the quality of care. This includes the guidance, advice and other tools that the National Institute for Health and Care Excellence provides for the</p>

		standards, and the National Institute for Health and Care Excellence and NHS England develop tools to support commissioners in commissioning for quality. The Department of Health will shortly consult on new regulations that will set out fundamental standards of care. The Care Quality Commission will then consult on sector-specific statutory guidance for providers that it will take into account when enforcing those regulations, including prosecution, and how it decides a rating. In this guidance the Care Quality Commission will signpost guidance and measures by the National Institute for Health and Care Excellence and other appropriate bodies.	health and care system, the support the Care Quality Commission provides for the development and implementation of the National Institute for Health and Care Excellence guidance, quality standards and indicators, and the support the National Institute for Health and Care Excellence provides to the Care Quality Commission in order for the Care Quality Commission to fulfil its role in the regulation of health and social care services. In July 2014, the Care Quality Commission consulted providers, health care professionals and other key stakeholders on proposed guidance on meeting new fundamental standards regulations. The draft guidance referenced the National Institute for Health and Care Excellence's technology appraisals, guidelines and quality standards. The Care Quality Commission has published final guidance on how organisations may comply with the duty of candour and the fit and proper person requirement for NHS bodies which came into force in November 2014. The Care Quality Commission will publish guidance on meet the remaining fundamental standards prior to them coming into force in April 2015.
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 specialities, professional organisations, and patient and public representatives, and consideration of the benefits and value for money of possible staff: patient ratios.	Accepted. The Department of Health have therefore tasked the National Institute for Health and Care Excellence to set out authoritative, evidence-based guidance on safe staffing. By Summer 2014, the National Institute for Health and Care Excellence will have produced guidance on safe staffing in acute settings, including its view of existing staffing tools. This initial phase will be followed by further work to develop full accreditation of staffing tools against the evidence-based guidance, and work on safe staffing in non-acute settings, including mental health, community services and learning disability. The focus of the work will be nursing and maternity staffing levels, but it will also take into account the importance of getting skill mix right and the wider context of other workforce groups, along with the importance of multi-disciplinary working in modern healthcare. The work led by the National Institute for Health and Care Excellence will be driven by an independent advisory committee for staffing. This will consider the evidence and draft the guidance, but it will also be able to signal the need for changes to existing tools where the evidence clearly indicates that there is an urgent need for them to be updated. Ahead of the work being undertaken by the National Institute for Health and Care Excellence, the National Quality Board is publishing alongside this response a guidance document that sets out the current evidence on safe staffing and makes clear the immediate expectations on all NHS bodies what they must do to ensure that every ward and every shift has the staff needed to ensure that patients receive safe care. NHS Trusts should therefore, from today, take account of the guidance issued by the National Quality Board. They should follow this advice until guidance developed by the National Institute for Health and Care Excellence advisory committee for staffing is rolled-out from Spring 2014. The guidance issued by the National Institute for Health and Care Excellence is not expected to include absolute staffing ratios given the inflexibility of such an approach, and the potential risks and disadvantages that the rigid application of ratios could have for patient care. The guidance will, however, provide an evidenced, authoritative basis for staffing decisions. The National Institute for Health and Care Excellence, NHS England, Health Education England and other national organisations will work together to ensure that NHS Trusts have the tools they need to make decisions to secure safe staffing; and these decisions will then be subject to external scrutiny and challenge by commissioners, regulators and the public, and inspection by the Chief Inspector of Hospitals.	The National Quality Board staff guidance document to support providers and commissioners to make the right decisions about nursing, midwifery and care staffing capacity and capability was published in November 2013. The National Institute for Health and Care Excellence is working over a three-year period on guidance on safe staffing in nine different settings (including acute, community, mental health, and learning disability). A consultation on the first setting, adult acute wards, ran from 12 May to 10 June 2014 and the guidance was published in July 2014. This recommends a systematic approach at ward level to ensure that patients receive the nursing care they need, regardless of the ward to which they are allocated, the time of the day, or the day of the week. The National Institute for Health and Care Excellence have been consulting on draft guidance on safe staffing in maternity settings between October and November 2014 and they expect to publish the guidance shortly
24	Compliance with regulatory fundamental	Accepted.	Between April and June 2014, the Care Quality Commission consulted on how it

	<p>standards must be capable so far as possible of being assessed by measures which are understood and accepted by the public and healthcare professionals</p>	<p>The Care Quality Commission has consulted on fundamental standards of care, which the Department of Health will reflect in regulations. The Care Quality Commission will engage with the public, providers and professionals to develop guidance that makes clear what it will take into account when enforcing the regulations, and prepare a handbook on how it awards ratings.</p> <p>In June 2013, the Care Quality Commission issued <u><i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i></u>. This document started the public discussion on what the fundamental standards of care should be. The consultation engaged 5,154 individuals and 4,500 organisations, and held 41 consultation events. On 17 October 2013, the Care Quality Commission published the responses to the consultation in <u><i>A new start: Responses to our consultation on changes to the way the Care Quality Commission regulates, inspects and monitors care services</i></u>, which showed that there is broad agreement with the new approach.</p> <p>The Department of Health will shortly consult on the draft regulations; these will set in legislation the fundamental standards of care as outcomes that must be avoided; they will also streamline and improve the clarity of requirements that must be positively achieved in order for a provider to register with the Care Quality Commission (these requirements were called 'expected standards' in its consultation.) Subject to Parliament, the regulations will come into force during 2014.</p> <p>While the focus is on hospital services in the first instance, in October 2013 new Chief Inspectors of General Practice and Adult Social Care took up post in the Care Quality Commission, and it will extend and develop guidance on the regulations for providers into all three of the Chief Inspectors' respective sectors. The Deputy Chief Inspector of Mental Health will report to the Chief Inspector of Hospitals on how this applies to mental health services.</p> <p>The three Chief Inspectors will engage the public, professionals and providers in developing guidance for all sectors. Attention will be given to how the fundamental standards of care are presented to the public, in particular so as to clarify the relationship to rights under the NHS Constitution and consumer rights.</p> <p>Many of the fundamental standards of care will include human rights dimensions, for example, subject to Parliamentary approval, they will confer a duty on providers to, among other things, treat people with dignity and respect, protect them from abuse, involve them in their care, and look after their care and welfare. The fact that fundamental standards of care will cover issues also protected by human rights means that patients and other service users will have additional protection to that which already exists under equality legislation and the Human Rights Act 1998.</p>	<p>planned to change the way it regulates, inspects and rates care services. As part of this, it carried out 36 consultation events, hearing from over 700 people including members of the public, organisations that represent people who use services, providers, commissioners and staff. It received over 400 responses through its online web form and just under 200 written responses</p> <p>The Care Quality Commission has also recently published a series of provider handbooks. These will sit alongside the guidance on the regulations and describe the end to end inspection process, including how the Care Quality Commission will judge what good quality care looks like and how the Care Quality Commission will rate providers. The handbooks cover <u>hospitals, specialist mental health services, community health services, adult social care, and GP and out of hours services</u>.</p> <p>The Government has passed legislation that will put in place new fundamental standards as requirements for registration with the Care Quality Commission. These fundamental standards set the level below which care must not fall. Where providers fail to meet these standards the Care Quality Commission will be able to use its enforcement powers to protect patients and service users from the risks of poor care – including prosecuting providers where a failure to meet a fundamental standard results in avoidable harm to a patient or service user, or a significant risk of such harm.</p> <p>The fundamental standards will come into force for all providers registered with the Care Quality Commission in April 2015. Two new regulations introducing a duty of candour for NHS bodies and a fit and proper person requirement for directors of NHS bodies came into force in November 2014.</p> <p>In July 2014, the Care Quality Commission consulted providers, health care professionals and other key stakeholders on proposed guidance on meeting new fundamental standards regulations. The Care Quality Commission has published final guidance on how organisations may comply with the duty of candour and the fit and proper person requirement for NHS bodies which came into force in November 2014. The Care Quality Commission will publish guidance on meet the remaining fundamental standards prior to them coming into force in April 2015.</p>
25	<p>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.</p>	<p>Accepted.</p> <p>The Academy of Royal Medical Colleges and Faculties are committed to delivering consistent and high quality patient experiences and outcomes and will continue to support the design, implementation and review of clinical standards and the processes for assuring their use.</p> <p>The Academy will do this in a patient-focused way and in conjunction with key partners. The Academy of Royal Medical Colleges and Faculties have always taken an active leadership role in setting clinical service delivery standards. In addition, with individual Royal College and Faculty activity such as accreditation schemes and invited reviews and the Academy's membership of the National Institute for Health and Care Excellence's Implementation Collaborative, involvement in assuring compliance with clinical standards is continuing to strengthen.</p> <p>In response to the Inquiry, the Academy and the National Institute for Health and</p>	<p>The medical Royal Colleges and Faculties continue to develop standards within their specialist areas and provide direct input to the development of the National Institute for Care and Health Excellence's guidance with the aim of driving improvement in health and patient care.</p> <p>The Colleges are working with the Care Quality Commission on their contribution to the regulator's standards and inspection processes. This work will be continuing during 2015.</p> <p>The relevant Colleges have been actively involved with NHS England in the publication of consultant treatment outcomes data for specific specialties.</p> <p>Work is also being taken forward to develop the scope and remit of Colleges' supported service accreditation schemes and, particularly to ensure consistency of approach, including a common framework and set of standards for accreditation across services and specialties</p>

		<p>Care Excellence are also working to agree and implement how medical and other Colleges will contribute to the development of outcomes measures. For example, on staff suitability and competence; evidence based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix; and measures of standards compliance.</p> <p>The Care Quality Commission will look at the implementation of the National Institute for Health and Care Excellence clinical and other guidelines as part of their inspection process and there is a move to greater transparency of clinical outcomes – NHS England has for the first time published clinical outcomes by consultant for ten medical specialties and has also begun to publish data on the friends and family test.</p>	
26	<p>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.</p>	<p>Accepted.</p> <p><u>In <i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i></u>, the Care Quality Commission consulted on new approaches to inspection which fully reflect this recommendation. On 17 October 2013, it published the responses to the consultation in <u><i>A new start: Responses to our consultation on changes to the way the Care Quality Commission regulates, inspects and monitors care services</i></u>, which showed that there is broad agreement with the new approach. It has appointed a Chief Inspector of Hospitals to take the new approaches forward, starting in acute hospitals, but also alongside new Chief Inspectors of General Practice and Adult Social Care, who will extend and develop the approaches for their respective sectors over time. The Deputy Chief Inspector of Mental Health will report to the Chief Inspector of Hospitals on how this applies to mental health services.</p> <p>The first of new hospitals inspections have already begun, and the Care Quality Commission is reviewing its approach to carrying out investigations in light of its new inspection methodology, the single failure regime and the learning from its report of its own regulatory process at University Hospital of Morecambe Bay.</p> <p>Through the use of larger inspection teams and longer inspection visits, the Care Quality Commission inspections now include more observation of care and contact with patients and staff. The use of specialist inspectors means a stronger focus on practice and case note review. A key part of the new inspection is to hold 'listening events' prior to each inspection to inform the focus of the inspection. The overall focus on quality, rather than regulations, means far less emphasis on checking policies and procedures.</p> <p>The Care Quality Commission's large, specialist inspection teams, and their focus on the delivery and experience of services rather than only on compliance with regulations, means that the new inspections are able to include in-depth investigation of individual providers.</p> <p>The Care Quality Commission also has a specific power of investigation which can cover providers, services across providers, and commissioners. The Care Quality Commission is reviewing its approach to using this power.</p>	<p>Under the leadership of the Chief Inspectors, the Care Quality Commission has put in place specialist inspection teams that subject providers to greater scrutiny. Inspections now routinely involve expert inspectors and people with experience of receiving care.</p> <p>The Care Quality Commission inspection teams will hold a public listening event before the start of their site visit or on the evening of the first day. The Care Quality Commission may plan additional listening events depending on the size, geographical spread and demographic profile of the trust. These events are intended for members of the public, so the trust's management and press are discouraged from attending. The listening events are promoted through appropriate public communications channels, for example, local community group newsletters and local media.</p> <p>The inspection team will also interview directors of the trust and staff at all levels, at a minimum interviewing the chair, chief executive, medical director, director of nursing, chief operating officer, director of finance, non-executive director responsible for quality/safety, board director responsible for end-of-life care, service leads for the core services and the complaints lead. The inspection team will also hold focus groups and individual interviews including junior doctors, registered nurses and midwives, consultants and other medical staff, student nurses and healthcare assistants, administration and support staff and foundation trust council of governors.</p> <p>The Care Quality Commission recruits, trains and supports people who use services- known as 'Experts by Experience'- to accompany its inspection staff on inspections of health and social care services and its visits to monitor the use of the Mental Health Act.</p> <p>Experts by Experience also attend listening events, consultations and staff training events and take part in activities to develop the Care Quality Commission's strategy and processes. The Care Quality Commission currently works with around 500 Experts by Experience covering a wide variety of backgrounds.</p> <p>During inspections, Experts by Experience spend time talking to people who use the service and observing the environment. They have first-hand experience of receiving care so they know which questions to ask to get as much information from the visit as possible. Their findings are used to support the inspector's judgment on the service and can also be included in the inspection report.</p>
27	<p>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</p>	<p>Accepted.</p> <p>The Care Quality Commission's new approach to inspection includes clearly recognising and encouraging high quality care through ratings which will highlight outstanding practice. But where it identifies concerns, the Care Quality Commission will also have the ability to act swiftly and firmly on it.</p>	<p>New Fundamental Standards regulations come into force for all providers of health and social care in April 2015. The Care Act 2014, which received Royal Assent in May 2014, created an additional form of warning notice specifically for NHS trusts and foundation trusts, which the Care Quality Commission can issue when it judges that a trust requires significant improvement. This warning notice can lead to the provider entering the failure regime and is intended to come into</p>

	<p>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.</p>	<p>The Department of Health will consult shortly on new regulations which will make clearer the fundamental standards of care, and enable enforcement against them without a prior warning notice. Subject to Parliamentary approval, the regulations will come into force during 2014.</p> <p>The Care Quality Commission will consult on a new enforcement policy for all sectors, making clear how any breach of the fundamental standards of care will be acted upon, so that these new regulations can be enforced effectively as they come into effect. Through its policies, the Care Quality Commission will ensure its actions are as transparent and understandable to the public as possible, and that information is made available about providers subject to enforcement.</p> <p>For NHS Trusts and NHS Foundation Trusts there is a single failure regime to ensure that the various means of holding NHS providers to account for failures of finance or governance are equally available for failures of quality. It ensures that the Chief Inspector of Hospitals' concerns trigger action by commissioners, the NHS Trust Development Authority or Monitor, rather than the Care Quality Commission acting alone. The action triggered includes credible strong sanctions, such as a managed process for placing a provider into administration and reconfiguring its services.</p> <p>While this new approach to effective action in the NHS has already started, it will be further underpinned by legislation upon adoption of the Care Bill, currently before Parliament. The new legislation will strengthen the current administrative arrangements and give a statutory basis for the means by which, through the Chief Inspector, the Care Quality Commission refers a Foundation Trust to Monitor for intervention.</p>	<p>force at the same time as the fundamental standards are introduced.</p> <p>Special measures will apply to NHS trusts and foundation trusts that have serious failures in quality of care and where there are concerns that existing leadership cannot make the necessary improvements without support. NHS trusts are put into special measures by the NHS Trust Development Authority while foundations trusts will be put into special measures by Monitor.</p> <p>Generally, this happens following a recommendation by Professor Sir Mike Richards, Chief Inspector of Hospitals. In May 2014, the Care Quality Commission, Monitor and the NHS Trust Development Authority published joint guidance on how the special measures programme works for NHS trusts and Foundation Trusts. The guidance explains why a trust would be placed in special measures, what happens during the special measures period, the roles and responsibilities of the Trust, the Care Quality Commission, Monitor and the NHS Trust Development Authority, and how trusts exit special measures.</p>
28	<p>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 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.</p>	<p>Accepted.</p> <p>The Government agrees that decisive action must be taken in response to a failure of quality of care and just as there is a clearly defined end point for hospitals that are financially unsustainable, the same principle must apply for those that are clinically unsustainable. This process must ensure problems can be rectified quickly while allowing essential services to continue and without compromising patient safety.</p> <p>The Care Quality Commission has clear legal powers to take swift and decisive action if patients are at immediate risk of harm, ensuring that the service or ward in question is closed immediately until the risk is addressed. New fundamental standards will be introduced which will set the level below which standards of care should not fall. Where the Care Quality Commission finds an NHS Trust or Foundation Trust to be failing systematically, for example with serious or repeated breaches of the fundamental standards, it will issue a warning notice requiring the provider to improve within a fixed period. If problems persist, the NHS Trust Development Authority, for an NHS Trust, or Monitor, for an NHS Foundation Trust will intervene. Levels of service performance and standards of care quality form part of Monitor's regular risk assessment of Foundation Trusts including the Care Quality Commission judgements on the quality of care provided. Monitor also expects licence holders to notify them in the event of any incident, event or report that may raise potential concerns over compliance with the licence. Breaches of licence conditions will attract enforcement action that can range from informal action, imposition of special licence conditions, removal or suspension of directors and revoking provider's licence.</p> <p>In instances where, but not limited to, the Chief Inspector of Hospitals considers that standards of care quality are inadequate the Care Quality Commission may recommend that the NHS Trust Development Authority or Monitor place the Trust into special measures. Special measures provide a framework for action where it is</p>	<p>From April 2015, along with the introduction of new fundamental standards, the Care Quality Commission will have new enforcement policy for all providers. The key difference is that the new policy will allow the Care Quality Commission to take the most appropriate action straight away. For example, the Care Quality Commission will be able to prosecute a provider without first issuing a warning notice, if that is the right thing to do. The Care Quality Commission will use these new arrangements to protect people who use regulated services from harm and the risk of harm and to hold providers and individuals to account for failures in how the service is provided.</p> <p>The changes to the Care Quality Commission's enforcement policy do not mean that the principles that underpin effective enforcement will change. The effective use and deployment of the Care Quality Commission's powers are achieved through robust evidence gathering at the outset, consideration of the range of enforcement tools available and taking action that is proportionate to the concerns identified and the impact on people who use services.</p> <p>The Care Act 2014 has created an additional form of warning notice specifically for NHS Trusts and Foundation Trusts. The Care Quality Commission will issue these where it judges that a trust requires significant improvement. When there are failures in the quality of care within NHS trusts the Care Quality Commission works closely with Monitor and the NHS Trust Development Authority. This warning notice can lead to the provider entering the failure regime.</p> <p>Further progress has been made in ensuring more robust accountability for individuals. A new fit and proper person test for directors of NHS Trusts was put in place in November 2014, and in April 2015 will be extended to all providers of health and adult social care registered with the Care Quality Commission. This test is being introduced as a new requirement for registration and places a requirement on providers to take steps to ensure that their Board level Directors are fit to perform the role to which they are appointed, and provides the Care</p>

	<p>not thought probable that the Trust leadership can secure the necessary improvements in quality without intensive intervention. Such interventions would be led by Monitor or the NHS Trust Development Authority and can include formal partnering with a high performing Trust to share best practice and guidance, a full leadership capability review including the ability to replace directors, creation of a public 'Improvement Plan', and the appointment of an Improvement Director to oversee progress. Typically the Chief Inspector will re-inspect the Trust after a year to ascertain whether the required improvements are being made.</p> <p>Ultimately, if it proves impossible for an NHS Trust or an NHS Foundation Trust to turn their performance around, Monitor, or the NHS Trust Development Authority (through a recommendation to the Secretary of State), will be able to place the organisation into special administration on quality grounds. Special administration will provide a framework for determining how best to secure a comprehensive range of high quality services that are both financially and clinically sustainable. As a backstop, if the Care Quality Commission considers that Monitor or the NHS Trust Development Authority has erred in not placing a trust into special administration it will be able to compel them to initiate the process.</p> <p>The Department of Health will revise the requirements for registration with the Care Quality Commission so that they will include fundamental standards. Under the revised registration requirements the intention is that it will be possible to prosecute providers in the most serious cases of poor care without the need for an advance warning notice. These new powers will build on and be compatible with powers already provided to the Care Quality Commission under the provisions of the Mental Health Act 1983 (as updated and amended by the Mental Health Act 2007) and supported by the Code of Practice to the Mental Health Act 2012 to monitor the use of the Mental Health Act and protect the interests of people whose rights are restricted under that Act.</p> <p>For individual healthcare providers, Monitor and the NHS Trust Development Authority have a range of intervention powers. For example, Monitor is able to remove, suspend or replace NHS Foundation Trusts' Governors or Directors. The NHS Trust Development Authority is able to remove Directors in NHS Trusts. The Department has also consulted on proposals that will allow the Care Quality Commission to hold Board members to account for the provision of poor care, which could result in them being removed from their posts. The Care Quality Commission does not have the power to take action against individuals. However, in instances where an individual is found to have caused death or serious harm, existing legislation can be used by the appropriate authority to hold them to account, as has happened with staff who were charged with neglect or ill-treatment at Winterbourne View. In addition, the Government agrees with Professor Don Berwick's recommendation that there should be legal sanctions where individuals or organisations are guilty of wilful neglect or mistreatment of patients. This will help ensure there is ultimate accountability for those guilty of the most extreme types of poor care. The Government will seek to legislate on this, and will work with stakeholders beforehand to determine the details of this measure, and will consult on proposals for legislation as soon as possible.</p> <p>Professional regulators can take a decision to remove clinical practitioners through the fitness to practice processes. The Nursing and Midwifery Council has responded to say that it will undertake a comprehensive review of its current Code in the light of the recommendations in the Inquiry report to explore how key messages can be strengthened and developed. This will include ensuring that a duty to comply with any relevant national fundamental standards is addressed in the revised Code. The General Medical Council is undertaking a programme to reform its fitness to practice processes including speeding up investigations work, modernising and streamlining the adjudication procedures and strengthening confidence in the independence of its adjudication function. The latter has resulted in the launch of the Medical Practitioners Tribunal Service in June 2012.</p>	<p>Quality Commission with a power to insist on the removal of Directors that it considers do not meet the fitness requirement.</p> <p>Professional regulation is also being strengthened. From 31 March 2015, nurses and midwives registered in the UK must practise in line with an updated Code of professional standards of practice and behaviour. This revised code will replace the 2008 Nursing and Midwifery Council Code. The 2015 Code has been updated to reflect changes in contemporary professional nursing and midwifery practice, and wider societal expectations of health and social care, in order to drive continuous improvement in the quality and safety of care. The Nursing and Midwifery Council has also produced guidance for Fitness to Practise panel members called 'Guidance for decision makers on insight, remediation and risk of reoccurrence' which has explicit requirements in relation to candour and near misses.</p> <p>The Government has also introduced an Order under Section 60 of the Health Act 1999, which came into force on the 11 December 2014 and makes amendments to the Nursing and Midwifery Order 2001. This will enable the Nursing and Midwifery Council to carry out its fitness to practise processes more efficiently. This is set out in more detail in the update to recommendation 228.</p> <p>As the next step in the General Medical Council's programme of reform to its fitness to practise procedures, the Department is working with them to develop legislation to establish the Medical Practitioners Tribunal Service in statute and modernise the fitness to practise procedures involving doctors. This includes a number of measures to make the fitness to practise procedures at the adjudication stage swifter and more effective. The intention is that an Order under Section 60 of the Health Act 1999 will amend the grounds on which the Professional Standards Authority for Health and Social Care can refer a fitness to practise panel decision to the higher courts and introduce a corresponding new right of appeal for the General Medical Council.</p>
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29	<p>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 practical steps have been taken to prevent a breach, including having in place a prescribed system to prevent such a breach.</p>	<p>Accepted.</p> <p>We agree that there should be serious consequences for any organisation that breaches basic quality standards in the provision of care.</p> <p>In its response to the Inquiry, <u>Patients First and Foremost</u>, the Government committed to draw up a new set of fundamental standards of care that will sit within the legal requirements that providers of health and adult social care must meet to be registered with the Care Quality Commission. The fundamental standards of care set a clear bar below which standards of care should not fall and focus on the very basics of care that matter to people and will be easily understood by all. These fundamental standards will be consulted on soon, and further details of this are set out in recommendation 13.</p> <p>There will be immediate, serious consequences for services where care falls below these standards. Subject to the passage of regulations, the Care Quality Commission will have new powers during 2014, including the ability to prosecute a provider for failing to provide fundamental levels of care, without having to issue a formal warning first. See recommendation 28 for further details.</p>	<p>The Care Quality Commission have made progress in ensuring that providers can be held to account where they provide care that is of an unacceptable standard.</p> <p>When the new fundamental standards come into force in April 2015, the Care Quality Commission will publish a new enforcement policy for all providers. This will allow the Care Quality Commission to take the most appropriate action straight away. For example, the Care Quality Commission will be able to prosecute a provider without first issuing a warning notice, where appropriate. The Care Quality Commission will use these new arrangements to protect people who use regulated services from harm and the risk of harm and to hold providers and individuals to account for failures in how the service is provided.</p> <p>The changes to the Care Quality Commission's enforcement policy do not mean that the principles that underpin effective enforcement will change. The effective use and deployment of the Care Quality Commission's powers are achieved through robust evidence gathering at the outset, consideration of the range of enforcement tools available and taking action that is proportionate to the concerns identified and the impact on people who use services.</p>
30	<p>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.</p>	<p>Accepted.</p> <p>As part of the overall single failure regime (see recommendation 19) it is important that where the Care Quality Commission identify breaches of fundamental standards that it is able to act quickly. As such the Care Quality Commission will retain its ability to stop a service from providing care if it is putting people at immediate risk of harm as outlined by the <u>Health and Social Care Act 2008</u>. The Act states that where the Care Quality Commission has "reasonable cause" to believe that unless it acts people may be exposed to the risk of harm, it may impose, or vary a condition of a provider's registration or suspend it from the point written notice is given as part of an urgent response.</p> <p>In addition, subject to the passage of regulations, during 2014 the Care Quality Commission will also have new powers to prosecute a provider for failing to provide fundamental levels of care, without having to issue a formal warning first. See recommendation 28 for further details.</p> <p>The powers outlined above are supported by the Care Quality Commission's new regulatory model, and its new approach to inspections. This approach is outlined in more detail in recommendations 50 and 51.</p>	<p>The Care Act 2014 has created an additional form of warning notice specifically for NHS Trusts and Foundation Trusts. The Care Quality Commission can now issue these where it judges that a trust requires significant improvement (not necessarily tied to breaches of regulations). This warning notice can lead to the provider entering the failure regime. Also, subject to the passage of regulations during 2014, the Care Quality Commission will have new powers to prosecute a provider for failing to provide fundamental levels of care, without having to issue a formal warning first.. The intention is that regulations will be in place in April 2015.</p>
31	<p>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.</p>	<p>Accepted.</p> <p>We agree that where routine monitoring and inspection identifies risks to patients' safety, regulators must be able to intervene swiftly and in a coordinated way that promotes joint action as part of a single failure regime (see recommendation 19).</p> <p>In April 2013 a network of local and regional Quality Surveillance Groups was established that brought together commissioners, regulators, local Healthwatch representatives and other bodies on a regular basis to share information and intelligence about quality across the system, including the views of patients and the public. Quality Surveillance Groups help to proactively spot potential problems early on and coordinate any action that is needed to respond where risks to patients are identified. Where potential concerns arise of a serious failure, members of the Quality Surveillance Groups will be able to act quickly by triggering a risk summit. All Quality Surveillance Group members relevant to the provider in question attend these summits so that they can, together, give specific, focused consideration to the concerns raised and develop a joined-up response.</p>	<p>Under the new special measures regime, the NHS Trust Development Authority and Monitor are now able to intervene at providers which the Care Quality Commission judge to be providing poor quality care as part of their new inspection programme. This includes partnering the failing provider with a high-performing buddy, the appointment of a dedicated Improvement Director at the trust as well as other targeted interventions to ensure rapid improvements where failings have been identified.</p>

		<p>As part of its regulatory model, the Care Quality Commission monitors evidence and information to detect if a provider is performing outside of what would be expected. This includes the monitoring of a small set of key measures that have a high impact on people and can alert the Care Quality Commission to changes in those areas. These include mortality rates, never events, results from staff and patient surveys, information from whistleblowers, comments from patients and the public on the quality of care, and information from Quality Surveillance Groups. Any indicator within that set which points to a potential concern will trigger a response from the Care Quality Commission depending on the concerns raised.</p> <p>This may vary from asking the Trust for further information and an explanation to conducting an inspection or, in extreme cases, the suspension of a service. On 24 October 2013, the Care Quality Commission published for the first time surveillance data for all acute trusts as part of its new regulatory regime. For further details on the Care Quality Commission's new inspection and surveillance programme see the responses to recommendations 20, 50 and 51.</p> <p>The NHS Trust Development Authority published Delivering High Quality Care for Patients (April 2013) which outlines the oversight model that will use to hold non-Foundation Trusts to account for their performance. Where necessary, the NHS Trust Development Authority will directly intervene by requesting recovery plans and additional reporting, increasing engagement with the organisation, commissioning 'deep dive' investigations into a trust's performance, reviewing the skills and competency of the board, and commissioning interim support to provide additional management capacity.</p> <p>For NHS Foundation Trusts, Monitor will continue to assess breaches to its licence system that sets conditions covering financial viability and governance as well as other areas that reflect Monitor's expanded role within healthcare. Monitor's licence conditions include compliance with healthcare standards specified by the Secretary of State for Health, the Care Quality Commission, NHS England and statutory regulators of healthcare professions. To do this, Monitor uses a risk based system of regulation that determines the intensity of monitoring required for each Foundation Trusts. Where Monitor determines that a Foundation Trust has breached its licence it may impose additional conditions to resolve any concerns including where the Care Quality Commission has issued a warning notice to a Foundation Trust. These are in addition to Monitor's powers to apply discretionary requirements or seek enforcement undertakings from a provider that has breached its licence. Monitor also has a formal weekly process to review the need for intervention and, if required, calls urgent special meetings to take a formal decision to intervene where patient safety might be at risk. Decisions are closely informed by the views and actions of the Care Quality Commission but are not bound by them.</p>	
32	<p>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.</p>	<p>Accepted.</p> <p>As part of the overall single failure regime (see recommendation 19) it is important that where the Care Quality Commission, Monitor or the NHS Trust Development Authority identify breaches of fundamental standards that they can act swiftly to resolve those issues.</p> <p>As such, the Care Quality Commission has retained both its ability to impose enforcement action to ensure that patient safety risks are addressed and to stop the provision of a service where it is putting people at immediate risk of harm as outlined by the <u>Health and Social Care Act 2008</u>.</p> <p>Subject to the passage of appropriate regulations, the Care Quality Commission will also be able to prosecute a provider for failing to provide fundamental levels of care, without having to issue a formal warning first. See recommendations 28 and 30 for further details.</p>	<p>Under the new special measures regime, the NHS Trust Development Authority and Monitor are now able to intervene at providers which the Care Quality Commission judge to be providing poor quality care as part of their new inspection programme. This includes partnering the failing provider with a high-performing buddy, the appointment of a dedicated Improvement Director at the trust as well as other targeted interventions to ensure rapid improvements where failings have been identified.</p>

		Monitor and the NHS Trust Development Authority have retained their powers to intervene at their discretion if urgent action is required. Details of this are outlined as part of the response to recommendation 31.	
33	Insofar as health regulators do not consider they possess any necessary interim powers, the Department of Health should consider the introduction of the necessary amendments to legislation to provide such powers.	<p>Accepted in principle.</p> <p>The Care Quality Commission already has the power of immediate intervention where it considers that the quality of services to be insufficient or the safety of service users is at risk. The NHS Trust Development Authority and Monitor each have powers to intervene and direct change where it is considered necessary.</p> <p>The Department of Health will consult shortly on new regulations which will make clearer the fundamental standards of care and enable enforcement against them without a prior warning notice. The Care Quality Commission will consult on a new enforcement policy for all sectors so that these new regulations can be enforced effectively when they come into force, subject to Parliament, during 2014.</p> <p>In <i>Patients First and Foremost</i> the Government announced that the Care Quality Commission, Monitor and the Trust Development Authority would establish a single failure regime to provide clarity while retaining the Care Quality Commission and Monitor as separate regulators with defined responsibilities across health and social care. To support this, specific clauses within the Care Bill lay the framework for a simple, flexible process for tackling quality failures in trusts and to provide the Care Quality Commission with the powers to issue a new warning notice to trusts where there are systematic failures in the quality of services requiring improvement.</p> <p>To address failures of quality where providers are unable to resolve problems on their own, the Care Quality Commission will be able to prompt intervention from Monitor (for NHS Foundation Trusts) or the NHS Trust Development Authority (for NHS Trusts). If the Chief Inspector finds a serious breach of health and safety requirements, the Care Quality Commission would refer the matter immediately to the Health and Safety Executive, which in serious cases could decide to prosecute.</p> <p>The Care Quality Commission plans to introduce this programme in November 2013 through a protocol setting out how it, Monitor and the NHS Trust Development Authority will coordinate their respective powers of intervention. This will be underpinned by legislation when the Care Bill completes its Parliamentary passage.</p>	Under the new special measures regime, the NHS Trust Development Authority and Monitor are now able to intervene at providers which the Care Quality Commission judge to be providing poor quality care as part of their new inspection programme. This includes partnering the failing provider with a high-performing buddy, the appointment of a dedicated Improvement Director at the trust as well as other targeted interventions to ensure rapid improvements where failings have been identified.
34	Where a provider is under some form of regulatory investigation, there should be some form of external performance management involvement to oversee any necessary interim arrangements for protecting the public.	<p>Accepted in principle.</p> <p>It remains the responsibility of providers' Boards to identify and resolve risks to patients swiftly. However, where there are significant issues that require action the Care Quality Commission will issue an enforcement notice and it is the roles of Monitor or the NHS Trust Development Authority to ensure that this is complied with.</p> <p>The response to recommendation 19 outlines a single failure regime that can be enacted where risks to quality and patient safety are identified. As part of that regime, the Care Quality Commission, the NHS Trust Development Authority or Monitor will work together, with the Trust and its commissioners, to ensure that where concerns are raised, the Trust acts swiftly to resolve them and to protect patients.</p>	Under the new special measures regime, the NHS Trust Development Authority and Monitor are now able to intervene at providers which the Care Quality Commission are providing poor quality care as part of their new inspection programme. This includes partnering the failing provider with a high-performing buddy, the appointment of a dedicated Improvement Director at the trust as well as other targeted interventions to ensure rapid improvements where failings have been identified.
35	Sharing of intelligence between regulators needs to go further than sharing of existing concerns identified as risks. It should extend to all intelligence which when pierced together with that possessed by partner organisations may raise the level of concern. Work should be	<p>Accepted.</p> <p>The sharing of local intelligence between professional and system regulators in an appropriate and timely way is key to ensuring that risks to service users are identified and acted upon as needed. <i>The Government's response to the Caldicott Review</i> (Department of Health, September 2013) states that, 'Health and social</p>	<p>Revised guidance for Quality Surveillance Groups <i>How to make your Quality Surveillance Group Effective</i> was published in March 2014</p> <p>Despite NHS England restructuring its field force, there will continue to be 27 QSGs on their current footprint, and 4 regional Quality Surveillance Groups. Central information is not collected on the performance of Quality Surveillance</p>

	<p>done on a template of the sort of information each organisation would find helpful.</p>	<p>care professionals should have the confidence to share information in the best interests of their patients within the framework set out by [the Caldicott principles]. They should be supported by the policies of their employers, regulators and professional bodies.' The response to recommendation 252 outlines further how data can be shared through appropriate anonymised routes.</p> <p>At a local level, in April 2013 a network of local and regional Quality Surveillance Groups was established that brings together commissioners, regulators, local Healthwatch representatives and other bodies on a regular basis to share information and intelligence about quality across the system, including the views of patients and the public.</p> <p>Quality Surveillance Groups help to proactively spot potential problems early on and coordinate any action that is needed to respond where risks to patients are identified. Where potential concerns arise of a serious failure, members of the Quality Surveillance Groups will be able to act quickly by triggering a risk summit. All Quality Surveillance Group members relevant to the provider in question attend these summits so that they can, together, give specific, focused consideration to the concerns raised and develop a joined-up response.</p> <p>The National Quality Board is currently conducting a review of how the Quality Surveillance Group network is operating, and what support it needs to be as effective as possible. It will publish revised guidance and support materials by the end of the 2013 to support all Quality Surveillance Groups to reach their full potential.</p> <p>At a national level, professional and system regulators have agreements and Memoranda of Understanding supported, as appropriate, by statutory requirements to ensure information is shared. It is the responsibility of all organisations to review what information can, appropriately, be shared openly with its partners and the public to support transparency and improvement.</p> <p>As part of this agenda, the Care Quality Commission:</p> <ul style="list-style-type: none"> • uses a range of information from regulators and partners to supports its surveillance process and collects that data routinely to support its processes. For example, when any reports to prevent future deaths are produced by a coroner they are shared with the Care Quality Commission to support their understanding of risk (see recommendation 282); • contacts professional regulators, and others, to request relevant intelligence to inform them of the inspections that it is undertaking as part of its new regime and to request appropriate intelligence. The Care Quality Commission also collects information from the Nursing and Midwifery Council and the General Medical Council routinely to support its surveillance model and intelligence used within its data packs; • has a detailed memorandum of understanding with Monitor regarding the sharing of intelligence and the working practices that support this. The Care Quality Commission and Monitor will continue to review this document and update it in the light of the Care Quality Commission's A New Start; • will, as part of the single failure regime, send any notices regarding performance to Monitor and the NHS Trust Development Authority. 	<p>Groups, however anecdotal information suggests they have bedded in further and got into their stride in many parts of the country - with commissioners and regulators seeing them as a vital part of the quality infrastructure</p> <p>Information sharing between regulators: The General Medical Council has been working closely with the Care Quality Commission to build on its Memorandum of Understanding.</p> <p>The Care Quality Commission and the Nursing and Midwifery Council signed an updated memorandum of understanding in December 2013. The Memorandum of Understanding outlines the areas of cooperation between the two organisations, and was supplemented in July 2014 by a joint operating protocol</p> <p>The Nursing and Midwifery Council is undertaking an internal quality assurance exercise on its own practice under its Memoranda of Understanding, the results of which will inform Memoranda being developed with other regulators. It will first report on the activity occurring as a result of partnership agreements and then undertake a more qualitative assessment of the impact of its own practice on safety and quality.</p>
36	<p>A co-ordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and</p>	<p>Accepted.</p> <p>The <i>Health and Social Care Act 2012</i>, requires the Health and Social Care Information Centre to establish and operate a system for the collection or analysis of</p>	<p>The National Information Board ensures that the Health and Social Care Information Centre is the focal point for data collected at the national level and that it increasingly becomes a 'gateway' for those seeking new data collections. The Centre will continue to look for opportunities for standardising outputs in</p>

	<p>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.</p>	<p>information in connection with the provision of health services and adult social care in England, if so directed by the Secretary of State or NHS England. The Informatics Services Commissioning Group, established in 2013, has been set up to enable the Health and Social Care Information Centre to become the focal point for data collected at the national level and that it increasingly becomes a checkpoint for those seeking new data collections.</p> <p>The Health and Social Care Information Centre publishes more than 130 statistical publications annually via its website. It also publishes a range of national indicators and metrics many of which are available publicly through its indicator portal. This includes, for example, the Summary Hospital-level Mortality Indicator, indicators from the Quality Outcomes Framework and measures from the NHS Outcomes Framework.</p> <p>In addition, a range of metrics are collected and published by other organisations across the health sector that relate directly to the quality of patient care. This includes data on infection control published by Public Health England and information on safety incidents that are published by NHS England. From November 2013, NHS England will increasingly make such information accessible through NHS Choices in order to bring together the most reliable and relevant data from national web services and act as a 'front door' to the best information on health and social care on the internet.</p> <p>Published data can be readily accessed by regulators to assess the risk of non-compliance. Where needed, however, additional data can be made available to regulators, for example, through local arrangements such as direct memoranda of understanding with the appropriate data collector.</p> <p>Published Official Statistics are subject to the UK Statistics Authority's Code of Practice for Official Statistics (January 2009) which expects that statistical reports should be released as soon as they are ready to avoid unnecessary delays and that such publication should take into account the needs of data users and the public.</p> <p>In the light of this, and other similar recommendations in the Review, we expect that the Health and Social Care Information Centre should explore options and make proposals for using standard reporting formats that can be made more available to all organisations, in line with the 'do once and use many times' principle, with a view to improving consistency of analysis across the system.</p>	<p>the context of the dissemination activities (for example to support the Care Quality Commission's new inspection and intelligent monitoring activities), and it will work with its partners to explore how this approach might support their work.</p> <p>In addition, a range of metrics are collected and published across the health sector that relate directly to the quality of patient care. This includes data on infection control (Public Health England), safety incidents (NHS England) and patients' feedback reported on the NHS Choices website and, in future, through a national Health & Social Care Digital Service, which will be replacing NHS Choices. This new online service will bring together the most reliable and relevant data from national web services and act as a 'front door' to the best information on health and social care on the internet.</p>
37	<p>Trust Boards should provide, through quality accounts, and in 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 of the methods used to obtain 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.</p>	<p>Accepted.</p> <p>The National Health Service (Quality Accounts Regulations) 2010 the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (Quality Accounts) Amendment Regulations 2012 set out information that must be included within Part 2 of the Quality Accounts to ensure they are comparable including information on their compliance (see recommendation 246). The Quality Accounts are published nationally via the NHS Choices website to ensure that they are accessible and the information they contain on quality is available to patients and the public (see recommendation 247).</p> <p>We also agree that reports should not be confined to achievements and should reflect a balanced view of quality. Professor Sir Bruce Keogh's report Review into the quality of care and treatment provided by 14 hospital trusts in England (NHS England, July 2013) stated as an ambition that '<i>...patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level</i>'. This includes an action that the '<i>...the requirements for Quality Accounts for the 2014–15 round begin to provide a more comprehensive and balanced assessment of quality.</i>'</p>	<p>A review of Quality Accounts has taken place and engaged 180 stakeholders, including patients, carers, and service providers, Healthwatch, NHS England, NHS Trust Development Authority and Monitor. The Quality Accounts Stakeholder Group has updated the purpose of Quality Accounts; 'Quality Accounts should give the reader the confidence the organisation was being open and honest about the quality of services being provided and was committed to driving continuous quality improvement'. Following this review a Quality Accounts Data Dictionary was developed and published in March 2014 to improve the consistency of indicator data and definitions. A live set of frequently asked questions has also been published in March 2014 focusing on specific areas of quality account production, including further technical guidance relating to indicators and information about who has to produce a quality account. Both of these are hosted on NHS Choices and can be updated throughout the year. Organisations take their indicator reporting information from the Health and Social Care Information Centre Quality Accounts Portal for purposes of consistency and accuracy. The Health and Social Care Information Centre portal was refreshed in March 2014.</p>

		<p>NHS England will review Quality Accounts before the 2014–15 cycle to ensure that they give patients appropriate information regarding the services they use, and that they add value to the quality assurance infrastructure used by trusts, local and national organisations. The review will consider recommendations 246 to 251 concerning the Quality Accounts along with the action highlighted in Sir Bruce's report and will report in early 2014. It is expected that the review will be complete such that guidance can be issued in March 2014 and trusts advised of expected changes in early 2014.</p>	
38	<p>The Care Quality Commission should ensure as a matter of urgency that it has reliable access to all useful complaints information relevant to assessment of compliance with fundamental standards, and should actively seek this information out, probably via its local relationship managers</p>	<p>Accepted.</p> <p>In June 2013, the Care Quality Commission issued <i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i>. This made clear that information from individual members of the public who make complaints, raise concerns and provide feedback about the quality and safety of their care would be a vital source of information and that a well-led service or organisation would have a good complaints procedure that drives improvement. On 17 October 2013, it published the responses to the consultation in <i>A new start: Responses to our consultation on changes to the way the Care Quality Commission regulates, inspects and monitors care services</i>, which showed that there is broad agreement with the new approach.</p> <p>The Care Quality Commission already has a customer service centre which receives comments from the public, and it ensures that these comments are fed into inspections. No legal obstacles to the Care Quality Commission accessing information have been identified. Any bureaucratic obstacles to information sharing are being addressed through the development of information sharing protocols. The Care Quality Commission and the General Medical Council have published an operational protocol which sets out in detail how coordination and information sharing will work between the two regulators. The Care Quality Commission is in agreement with the Nursing and Midwifery Council that they will develop a similar joint working protocol by December 2013. Arrangements are in place for updated information sharing arrangements thereafter with the General Dental Council and the Health and Care Professions Council.</p> <p>The Care Quality Commission is examining how it needs to develop its systems further to ensure that it can use feedback and complaints from all sources to inform its inspection system, and ensure that people contacting the Care Quality Commission with information are clear what the Care Quality Commission will do with that information, and what action it may take in response. This work will be shaped by findings set out in <i>A review of the NHS hospitals complaints system: putting patients back in the picture</i>, and to ensure that complaints information and feedback from people who use services is embedded consistently and given significant weighting, the Care Quality Commission has committed to develop the way it uses these in its surveillance model by early 2014.</p>	<p>Ahead of any inspection, the Care Quality Commission requests a range of information relating to complaints from providers. This includes numbers of complaints, themes of complaints and the timeliness of resolution of complaints.</p> <p>The Care Quality Commission will also ask providers to share with us any survey they have carried out of people who have complained to them in the last 12 months.</p> <p>The new fundamental standards will place a legal requirement on registered providers to provide the Care Quality Commission with information about complaints.</p>
39	<p>The Care Quality Commission should introduce a mandated return from providers about patterns of complaints, how they were dealt with and outcomes.</p>	<p>Accepted in principle.</p> <p>Information from people, who use care services about the quality and safety of their care, including concerns and complaints, is a vital source of information which needs to be available to the regulator. As part of the introduction of its new approach to inspection, the Care Quality Commission will ensure that it has access to this information so that it is a central part of how it focuses inspections. Through its engagement activity and refinement of its new approach, the Care Quality Commission will consider how best to ensure that it has access to this information.</p> <p>The Care Quality Commission already accesses and uses a range of information about complaints to inform the timing and focus of its inspections. The information</p>	<p>Ahead of any inspection, the Care Quality Commission requests a range of information relating to complaints from providers. This includes numbers of complaints, themes of complaints and the timeliness of resolution of complaints.</p> <p>The Care Quality Commission will also ask providers to share with us any survey they have carried out of people who have complained to them in the last 12 months.</p> <p>The new fundamental standards will place a legal requirement on registered providers to provide the Care Quality Commission with information about complaints.</p>

		<p>ranges from aggregated numbers and patterns of complaints, to individuals who contact it and tell inspectors about their experience. The Care Quality Commission also has a Memorandum of Understanding with Monitor that allows the two-way sharing of patient complaints information so that Monitor can act on it.</p> <p>The Care Quality Commission started implementing its new approach to hospital inspection in September 2013. The approach is based around judging five dimensions of quality. In December 2013 it will set out information in more detail in a handbook for providers, so that there is transparency in how it will rate acute hospitals. This will build on the proposals in <u><i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i></u> by providing more detail on:</p> <ul style="list-style-type: none"> • what the five questions that the Care Quality Commission inspects* will cover; • the definition of each level of the rating scale (outstanding, good, requires improvement inadequate); • key lines of enquiry that will always be followed to ensure consistent ratings; • any additional indicators and data that contribute to the rating (beyond those used for surveillance), and any methods or rules for aggregating them; • how judgements are made from inspection findings and data, to place a provider in a ratings band. <p>In all inspections, the Care Quality Commission will use key information to identify priorities to check, and this will always include complaints information as an essential component. This is likely to require definition of a comprehensive, standardised information set which the Care Quality Commission can access as part of pre-inspection planning and as and when required for on-going monitoring.</p> <p>The information could be required on a mandatory basis by incorporating it in regulations or through the Care Quality Commission's general power to require access to whatever information it needs to exercise its functions. However, it is premature to make decisions on requiring mandatory information until the implications of Rt Hon Ann Clwyd MP and Professor Tricia Hart's <u><i>Review of the Handling of Complaints in NHS Hospitals</i></u> are fully understood, until the NHS Confederation's review of bureaucracy has reported, and the Care Quality Commission has evaluated its information requirements in light of its first inspections using its new approach. The Care Quality Commission will review whether to require routinely from providers a report on complaints, self-assessment or other form of declaration, in order to inform its monitoring and inspections, as it continues to test and engage on refining its new approach to inspection between now and April 2014.</p> <p>*Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well-led?</p>	
40	<p>It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.</p>	<p>Accepted.</p> <p>The new approach to inspection introduced by the Care Quality Commission places a stronger focus on how care is delivered in practice and how it is experienced, rather than only on compliance with regulations. In line with this, it is now making greater use of the information that it holds on complaints.</p> <p>The Care Quality Commission already uses a range of information about complaints to inform the timing and focus of its inspections. The information ranges from</p>	<p>The new inspection process being developed by the Care Quality Commission, working with the Patients Association, is to build an approach based on listening and focus groups, and an interview with the complaints manager. It may also involve looking through complaints file; in other words, looking at the whole complaints process.</p> <p>The Care Quality Commission provider handbooks were published in October 2014 and include mandatory key lines of enquiry for use in all inspections. For complaints this means the inspection finding evidence to answer the questions</p>

		<p>aggregated numbers and patterns of complaints, to individuals who contact the Care Quality Commission and tell inspectors about their experience. The Care Quality Commission will review how it makes best use of the complaints that it receives directly from individuals, and the individual stories in complaints as well as the aggregated trends, in light of Rt Hon Ann Clwyd MP and Professor Tricia Hart's <u><i>Review of the Handling of Complaints in NHS Hospitals</i></u></p>	<p>- How are people's concerns and complaints listened and responded to and used to improve quality of care? For staff concerns, evidence will be gathered to answer the questions – Is the value of staff raising concerns recognised by both leaders and staff? Is appropriate action taken as a result of concerns raised?</p> <p>Over the next six months, the Care Quality Commission plan to further strengthen this approach through:</p> <ul style="list-style-type: none"> • starting to design a set of training and support for inspection team members and other the Care Quality Commission staff that is likely to include issues such as understanding the legal framework, facilitating staff forums to ensure raising and acting on concerns is discussed, how to manage sensitivities in handling concerns such as confidentiality, use of inspection guidance and tool kits, identifying good and poor practice. • In terms of complaints handling, the Care Quality Commission plan in hospitals and other care sectors to carry out an audit of a randomly selected (by the Care Quality Commission) sample of closed files to understand if these have been handled in a way that matches the good practice they expect to see. • Interviews with senior management, including the Head of Human Resources or equivalent, will include questions about policies on and the practice of handling staff concerns. <p>There was a positive response when the Care Quality Commission engaged on their proposed approach with groups of people who have experience of making complaints, complaint advocacy services, staff who have raised concerns about services and national bodies. The Care Quality Commission have gathered, from their inspection activity, evidence of good and poor practice in the different sectors for a Chief Inspector of Hospitals report <u>Complaints Matter</u>, which was published in December 2014.</p> <p>The Care Quality Commission is also undertaking a wide review of “customer experience” that will understand how they can improve the way they listen and respond to concerns and complaints and the providers they regulate. This will include looking at good practice in other service sectors. They are also carrying out a review of their own whistleblowing policies using external expertise.</p> <p>The Care Quality Commission is building up the relationships it has with its strategic partners to reform the wider complaints system in order to align work on vision and standards, share good practice and consistency in messaging and on a joint vision for good complaints handling.</p>
41	<p>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</p>	<p>Accepted in principle.</p> <p>The Care Quality Commission already monitors compliance with patient safety alerts, such as those issued by the Medicines and Healthcare products Regulatory Agency, and is able to investigate further where it identifies the need to do so in order to hold providers to account for failures to act on them. The Care Quality Commission is currently exploring how it can give greater prominence to safety alerts in its revised surveillance and inspection model. However care is needed to be clear that providers retain accountability for implementing patient safety alerts. It is not the Care Quality Commission's role to oversee providers' individual decisions or actions. Providers must be able to explain and account for how they act on safety alerts; the Care Quality Commission's role will be to assess their capability and performance in terms of whether it results in good quality care.</p> <p>NHS England is developing proposals for a new system of safety alerts, and, to strengthen the ability to monitor alerts and compliance with them, the Care Quality Commission is closely involved in that work. The role of regulation is integrated into an overall approach that allows for both safety improvement and accountability.</p>	<p>The Care Quality Commission is giving greater prominence to safety alerts in its revised surveillance model. The Care Quality Commission's NHS acute Intelligent Monitoring system includes a composite indicator around completion of safety alerts which contributes to providers' risk scores.</p> <p>The Care Quality Commission is continuing to develop its approach to the use of data and intelligence, including the role of safety alerts, across all the sectors it regulates, both to inform risk identification and to support and test inspection findings, as an integral part of its new regulatory approach</p> <p>Providers are expected to retain accountability for implementing patient safety alerts while demonstrating safety improvement and learning in order to give safety alerts more prominence in the inspection model.</p>

42	<p>Strategic Health Authorities/their successors should, as a matter of routine, share information on serious untoward incidents with the Care Quality Commission.</p>	<p>Accepted.</p> <p>Information on serious untoward incidents is shared routinely with the Care Quality Commission, and Quality Surveillance Groups have been established to support the sharing of information and intelligence more generally at a local level.</p> <p>NHS England is the relevant successor to Strategic Health Authorities. It continues routinely and regularly to share with the Care Quality Commission information on serious untoward incidents reported to the Strategic Executive Information System and the National Reporting and Learning System.</p> <p>The Care Quality Commission has direct access to the Strategic Executive Information System, and is able to view all the information submitted to that system regarding serious incidents. Information on National Reporting and Learning System reported incidents is shared on a weekly basis with the Care Quality Commission.</p> <p>The Care Quality Commission is reviewing how it uses incident data in its new surveillance and monitoring approach to support inspections carried out on behalf of the new Chief Inspector of Hospitals, looking at both incident severity and levels/consistency of reporting. The Care Quality Commission and NHS England are working closely on these developments and have agreed to use the same indicators and approach to their analyses where this is possible.</p> <p>Quality Surveillance Groups have been established from April 2013 in each area and in each region. These groups actively share between commissioners, regulators, all local NHS organisations and others, information and intelligence on the quality of care being delivered, including on untoward incidents and how they are managed. The National Quality Board is currently conducting a review of how the Quality Surveillance Group network is operating, and what support it needs to be as effective as possible. It will publish revised guidance and support materials by the end of the 2013 to support all Quality Surveillance Groups to reach their full potential.</p>	<p>The Intelligent Monitoring tool analyses a range of information including information from the National Reporting and Learning System, as well as people's experiences of care, staff experience and analysis of statutory returns to the Care Quality Commission (for example, notifications of serious incidents).</p> <p>The indicators raise questions about the quality and safety of care but are not used on their own to make final judgments. These judgments will always be based on what the Care Quality Commission finds at inspection, which is informed by Intelligent Monitoring data and information from the service provider and other local sources.</p> <p>Since April 2013, a network of Quality Surveillance Groups has been established at a local and regional level across the country. Quality Surveillance Groups regularly bring together organisations from across the health economy to share information and intelligence on the quality of care being provided to their communities. Regional Quality Surveillance Groups share reports with key issues and concerns with each other and to the NHS England Executive Group on a regular basis so that any issues that need national attention and action can be escalated.</p> <p>To support Quality Surveillance Groups to be as effective as possible in fulfilling their role and potential, a review has been undertaken by the National Quality Board along with all organisations represented on the Quality Surveillance Groups. This has resulted in the publication of revised guidance for Quality Surveillance Groups, '<i>How to run an effective Quality Surveillance Group</i>'.</p>
43	<p>Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.</p>	<p>Accepted.</p> <p>Regulatory bodies and commissioners of NHS services do monitor media reports about relevant organisations for which they hold responsibility.</p> <p>Within the Care Quality Commission's new approach to inspection, it will be monitoring media reports with those contributing to decisions on when and where to inspect. They are reflected in the data packs the Care Quality Commission uses to focus its inspections. Monitor and the NHS Trust Development Authority monitor media reports about the organisations they regulate, and this information feeds into their assessment processes and on-going regulation activity. NHS England actively monitors media reports about clinical commissioning groups and providers. The Nursing and Midwifery Council monitors media coverage of potential fitness to practise issues relating to registered nurses and midwives, and opens investigations when serious concerns appear to have been raised. The General Medical Council conducts extensive monitoring of print, online, broadcast and social media as part of its commitment to be proactive in identifying risk to patients and patient care, and it opens investigations when there appears to be a serious concern.</p> <p>Since April 2013, NHS England has rolled out Quality Surveillance Groups across England. These groups actively share among commissioners, regulators and other organisations information and intelligence on the quality of care being delivered, including issues and cases of media and public interest. The National Quality Board is currently conducting a review of how the Quality Surveillance Group network is operating, and what support it needs to be as effective as possible. It will publish</p>	<p>The Care Quality Commission uses some media monitoring information in its acute inspection planning and its provider relationship teams are alerted to media stories about providers locally. The Care Quality Commission is now reviewing its approach to determine how it will use this source of intelligence in the future.</p>

		revised guidance and support materials by the end of the 2013 to support all Quality Surveillance Groups to reach their full potential.	
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 by the trust concerned to demonstrate that the learning to be derived has been successfully implemented.	<p>Accepted in part.</p> <p>The Care Quality Commission's new approach to inspection includes a published set of 'Intelligent Monitoring' indicators for monitoring quality in providers: for the first time indicators in relation to acute trusts were published on 24 October 2013, and these will be published quarterly. The indicators use information on serious incidents and avoidable harm, all of which is valuable to the Care Quality Commission. While it would not be feasible to follow up on every reported incident of patient harm as there are more than 250,000 incidents each year with over 200,000 of these categorised as low harm incidents, the Care Quality Commission has defined a number of these indicators as 'tier one indicators', which always trigger rigorous follow up action to obtain assurance. Tier one indicators include serious incidents such as 'never events'. The Care Quality Commission's new Intelligent Hospital Monitoring system will also trigger a response whenever there is a statistically significant number of severe harm incidents or avoidable deaths at a provider location. The Care Quality Commission also analyses information over time and takes action on patterns of differences between expected and observed outcomes of care, and patterns of incidents.</p> <p>The indicators on their own will not be used to draw definitive conclusions or judge the quality of care – that will be a matter for inspection. Instead the indicators will be used as 'smoke detectors', which will start to sound if a hospital is outside the expected range of performance for one or more indicators. The Care Quality Commission will then assess what the most appropriate response should be. Providers are required to inform the Care Quality Commission of a range of incidents that may point to failings in the care provided.</p> <p>The Care Quality Commission will consider further ways to monitor and act on incidents and avoidable harm as its new system of monitoring providers matures, in order continuously to improve its sensitivity to this aspect of quality of care. However, it needs to avoid any duplication with local arrangements for ensuring that providers address serious incidents and avoidable harms and demonstrate learning, as set out in NHS England's <i>Serious Incident Reporting and Learning Framework</i>. For this reason, while the Care Quality Commission should ensure high priority to responding to concerns about patient safety, it should not follow up <i>any</i> serious incident or avoidable harm, given that other arrangements are in place and the Care Quality Commission needs to target its resources where it will have greatest impact in promoting better quality care.</p>	<p>The Care Quality Commission's Intelligent Monitoring system triggers a response where there are a statistically significant number of severe harm incidents or avoidable deaths at a provider. 'Never events' trigger an automated elevated risk in Intelligent Monitoring which inspectors are expected to follow up individually. The Care Quality Commission uses this information to determine whether to inspect a provider and what line of enquiry to take on inspection.</p> <p>The Care Quality Commission is currently reviewing internally its role and approach to serious incident reporting and investigations, this includes a thematic probe into complaints, concerns and whistleblowing, a part of which is the examination of what the Care Quality Commission does with this information and how it can be used better.</p>
45	The Care Quality Commission should be notified directly of upcoming healthcare-related inquests, either by trusts or perhaps more usefully by coroners.	<p>Accept in principle.</p> <p>Coroners' investigations and inquests can provide useful information on the quality of services delivered by care providers and any risk of future deaths. As a result, the Care Quality Commission already receives <i>Reports to Prevent Future Deaths</i> and disclosure in inquests where they have interested person status.</p> <p>Since 25 July, coroners are under a statutory duty to make details of the date, time and place of all inquests available before hearings commence. However, in order to support its new inspection model, the Care Quality Commission may require further details regarding upcoming inquests.</p> <p>To this end, the Care Quality Commission will undertake an analysis of the information available from coroners' investigations and inquests, along with other information it already receives relating to expected and unexpected deaths. It will consider the findings of that analysis, including how it could target requests for information from coroners and any burden that collecting this data might impose,</p>	<p>The Care Quality Commission is undertaking an analysis of the information available from coroners' investigations and inquests, along with other information it already receives relating to expected and unexpected deaths. It will consider the findings of that analysis, including how it could target requests for information from coroners and any burden that collecting this data might impose, working with the Coroners' Society of England and Wales, the Office of the Chief Coroner, the Ministry of Justice and the Department of Health.</p> <p>In addition, the Care Quality Commission is also working with the Coroners' Society of England and Wales and the Office of the Chief Coroner in establishing a Memorandum of Understanding with the aim of achieving better working relationships and the sharing of information. The Care Quality Commission continues to receive prevention of future death reports, and received 127 notices between August 2013 and August 2014.</p> <p>The Care Quality Commission now has a single point within the Care</p>

		<p>working with the Coroners' Society of England and Wales, the Office of the Chief Coroner, the Ministry of Justice and the Department of Health. Together, they will develop an appropriate way forward.</p> <p>In addition, the Care Quality Commission is also working with the Coroners' Society of England and Wales and the Office of the Chief Coroner in establishing a Memorandum of Understanding with the aim of achieving better working relationships and the sharing of information between the Care Quality Commission and coroners.</p>	<p>Quality Commission where all Regulation 28 notices from Coroners are received. There is a central record to enable tracking of the regulations from receipt through to response and the Care Quality Commission has created detailed guidance on internal processes to facilitate earlier involvement in inquests including the provision of information. In the future there is the potential for a reporting capacity.</p>
46	<p>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.</p>	<p>Accepted.</p> <p>Replacing the quality and risk profile approach, since October 2013 the Care Quality Commission has published its analysis of risk indicators for the entire hospital sector, showing how all hospital providers perform against these indicators of risk. Updates will be published quarterly. Under its new inspection approach, spearheaded by the Chief Inspector of Hospitals, as it carries out each inspection under its new approach, the Care Quality Commission will publish the data pack at the same time as publishing the inspection report. A data pack is a detailed analysis of key information that the Care Quality Commission holds about a provider, including its performance on risk indicators, other sources of data, and qualitative information such as views of local organisations and feedback from patients.</p> <p>The Care Quality Commission's new approach is designed to support inspection by specialist teams, through inspections based on identifying lines of enquiry from whatever quantitative and qualitative information suggest about standards of care, rather than focused on regulations. Under the new approach the Care Quality Commission also analyses information about providers to decide the timing of inspections so that there is timely follow-up to potential concerns. This is to clarify the difference between on-going monitoring, and judgements by inspectors at certain points within that.</p> <p>The Care Quality Commission has begun its new approach to monitoring providers in the hospital sector. New Chief Inspectors of General Practice and of Adult Social Care took up post in October 2013 and will now spearhead the extension and development of new approaches to monitoring standards of care in those sectors. The Deputy Chief Inspector of Mental Health will report to the Chief Inspector of Hospitals on how this applies to mental health services.</p>	<p>In March and July 2014, the Care Quality Commission updated its surveillance model for acute NHS trusts and in July 2014, it published for the first time surveillance models for adult social care, general practice, community and mental health providers.</p> <p>In January 2014, the Care Quality Commission started its new inspection programme for mental health trusts, community trusts and general practice out of hours services. In April 2014, new style inspections started in adult social care. The first new inspections for ambulance services and dentists started in July 2014.</p>
47	<p>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</p>	<p>Accepted.</p> <p>The Care Quality Commission has taken steps to engage Overview and Scrutiny Committees and Foundation Trust Governors, to increase their input to its new approach to inspection and monitoring.</p> <p>All Overview and Scrutiny Committees now receive a two-monthly bulletin from the Care Quality Commission to update them on work and encourage feedback from their scrutiny reviews and activity. Each Overview and Scrutiny Committees has received a welcome letter from Professor Sir Mike Richards, the Chief Inspector of Hospitals. Local Trusts being inspected under the Care Quality Commission's first wave of new in depth inspections have received a second letter inviting them to the public listening events and encouraging specific feedback about the Trusts.</p> <p>The Care Quality Commission has put in place a contract with the Centre for Public Scrutiny to further develop information sharing and relationships with Overview and Scrutiny Committees across the regions. A sounding board of Overview and Scrutiny Committees was held in August 2013, which included encouraging Overview and Scrutiny Committees to access the Care Quality Commission's local data to inform</p>	<p>The Care Quality Commission works with overview and scrutiny committees by allowing them to access and use the information the Care Quality Commission holds about services to help them drive local improvements in care services. They also work with the Care Quality Commission to coordinate compliance monitoring with scrutiny committee activity where appropriate. In turn, the committees share information with the Care Quality Commission gathered from local communities about the quality and safety of health and social care services.</p> <p>The contract in place with The Centre for Public Scrutiny to deliver work across the country with overview and scrutiny committees will run until March 2015.</p> <p>The Care Quality Commission is developing a separate guide for local councillors and overview and scrutiny committees to working with the Care Quality Commission, due to be published in November 2014. The Care Quality Commission is developing similar guidance for Foundation Trust Governors. This is due to be published in early 2015.</p>

		<p>their scrutiny work programmes.</p> <p>The Care Quality Commission and Monitor have worked together so that Monitor's new <u>statutory guidance for Governors</u> provides briefing on the Care Quality Commission's role and new approach to inspection. It sets out ways in which Governors can have an effective role in the Care Quality Commission's monitoring and inspection, and how information should be shared.</p>	
48	<p>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</p>	<p>Accepted in principle.</p> <p>Professor Sir Mike Richards, the Chief Inspector of Hospitals, has already written to Foundation Trust Councils of Governors about the first wave of his new NHS Trust inspections, setting out how Councils of Governors can be involved in listening events, can feed in information to the inspections, and can contact the local Care Quality Commission manager if at any time they wish to raise questions or provide further information to it in relation to the quality of care provided by the trust. The Foundation Trust Council of Governors was used to convey this information to individual Governors because of their requirement to work collectively as a Council.</p> <p>The Care Quality Commission has worked with Monitor to ensure that Foundation Trust governors have clear guidance on the Care Quality Commission's role and how to raise concerns. This information will be available to governors on an on-going basis, and to newly appointed governors, in addition to the one-off letter that has been sent.</p>	<p>The Care Quality Commission has extended the independent panel for governors run by Monitor so that it now also acts as an independent panel for Councils of Governors to raise queries they have in relation to healthcare standards.</p> <p>The Care Quality Commission wrote to all Foundation Trust Councils of Governors in Autumn 2013 when it announced its new approach, informing them of the first wave of its new acute inspections. Following this, it was agreed that it would become part of the Care Quality Commission's methodology to invite the relevant Council of Governors to contribute evidence as part of an inspection. Further work is being undertaken to embed this.</p> <p>The Care Quality Commission is also undertaking work to ensure that there is an effective framework in place so that its hospital inspection teams know how Councils of Governors should be invited to contribute evidence. The Care Quality Commission will be publishing a briefing for all Foundation Trust Councils of Governors about its new approach and standards of care.</p>
49	<p>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:</p> <ul style="list-style-type: none"> • The Quality and Risk Profile; • Quality Accounts; • Reports from Local Healthwatch; • New or existing peer review schemes; • Themed inspections. 	<p>Accepted.</p> <p>The Care Quality Commission is fundamentally changing the way it monitors providers on the quality of their services. Through its Chief Inspector of Hospitals, it has introduced a new system in the hospital sector. The Chief Inspectors of General Practice and Adult Social Care have been appointed, and will similarly lead the development of new approaches in their sectors.</p> <p>The Care Quality Commission has consulted on and started implementing a new approach to monitoring providers, based on identification of the indicators that are most important in signalling potential concerns in each type of care. This has started in the hospital sector, and the Chief Inspector of Hospitals has been clear that information from people who use the service, or their representatives, information from accreditation and peer review, and information from other oversight bodies are also important alongside indicators from national data. In October 2013 the Care Quality Commission began regularly publishing its analyses of the indicators for each hospital trust.</p> <p>The Care Quality Commission will continue to develop the approach to monitoring hospitals, and extend it to mental health, community health and ambulance providers both in the NHS and the independent sector. The Chief Inspector of General Practice, on behalf of the Care Quality Commission, will bring forward proposals for his sector and consult on them. A signposting document on adult social care, <u>A fresh start for the regulation and inspection of adult social care</u>, was issued in October 2013 by the Chief Inspector of Social Care.</p> <p>The Care Quality Commission is engaged in a review of quality accounts that the National Quality Board has requested and will play its part in ensuring that quality accounts add value, are robust and have accountability for inaccurate or inappropriate information.</p> <p>The Care Quality Commission is developing Memoranda of</p>	<p>The Care Quality Commission has put in place a system of Intelligent Monitoring to help decide when, where and what to inspect. This draws information and data from a range of sources to identify providers and services where there may be a greater risk of providing poor care. The evidence from the Intelligent Monitoring system is used to prioritise which providers will be inspected and the lines of enquiry during an investigation. The system triggers a response, for example, where there are a statistically significant number of severe harm incidents or avoidable deaths at a provider. "Never events" trigger an automated elevated risk in Intelligent Monitoring which inspectors follow up individually. The data it looks at includes information from:</p> <ul style="list-style-type: none"> • Staff • Patient surveys • Mortality rates • Hospital performance information such as waiting times and infection rates <p>In October 2013 the Care Quality Commission began a pilot of its Intelligent Monitoring programme for acute and specialist NHS trusts. The pilot looked at more than 150 different sets of data (indicators), which related to the five key questions the Care Quality Commission asks of all services – are they safe, effective, caring, responsive, and well-led? Using this data, the Care Quality Commission grouped all acute NHS trusts into six priority bands for inspection. In March and July 2014, the Care Quality Commission updated its <u>surveillance model for acute and specialist NHS trusts</u>.</p> <p>In November 2014, the Care Quality Commission published Mental Health Intelligent Monitoring reports, which display the results of its analysis of Tier 1 indicators for all Mental Health NHS trusts. Each trust receives an individual report and banding, similar to those for acute hospitals. The bandings range from one to four.</p>

		<p>Understanding with all the medical, nursing and midwifery Royal Colleges in order to explore the potential to use their accreditation schemes in its monitoring, where that can encourage achievement of best practice standards and avoid duplicated inspection.</p> <p>The Care Quality Commission is reviewing its approach to themed inspections, including how they can contribute to its broader monitoring of providers.</p>	<p>In November 2014 the Care Quality Commission published its first round of Intelligent Monitoring for GPs</p> <p>The Care Quality Commission has always used important information in statutory notifications as an indicator of quality and safety in the adult social care sector, alongside other information about safeguarding alerts and information provided by others such as people who use services, staff and the public. The Care Quality Commission does not have a lot of quantitative data consistently collected across the sector but it is taking steps to improve this. With a new, more thorough model the Care Quality Commission intends to use all the available information to check whether there is a risk that services do not provide either safe or quality care.</p> <p>Draft Intelligent Monitoring models for the Adult Social Care sector have been in place since October 2014, with separate sets of indicators for residential, community and hospice services. The Care Quality Commission will continue to develop these models with providers and stakeholders to develop a more robust Intelligent Monitoring system within Adult Social Care during 2015/16 and beyond.</p> <p>The Care Quality Commission's Board agreed a new, strategic approach to thematic work in February 2014 that will enable the Care Quality Commission to develop an independent voice through bespoke thematic activity on priority topics. The Care Quality Commission will develop bespoke methods for each project, and this will mean that thematic findings can inform its surveillance, inspection and ratings when appropriate. Thematic work goes beyond inspection, and may include for example a data review which looks at information sources which are not part of the Care Quality Commission's routine intelligence monitoring.</p>
50	The Care Quality Commission should retain an emphasis on inspection as a central method of monitoring non-compliance.	<p>Accepted.</p> <p>The Care Quality Commission has introduced a fundamentally different and strengthened approach to inspection as the centrepiece of how it assures standards of care.</p> <p>The Care Quality Commission's new approach to inspection involves large teams of specialists and public listening events, resulting in judgements about the quality of care rather than compliance with regulations. The new approach is led by the Chief Inspector of Hospitals, Professor Sir Mike Richards; several thousand specialists and members of the public have put themselves forward to join his inspection teams. This level of engagement, and the more relevant outputs, ensures that inspection is at the heart of the Care Quality Commission's role and purpose. The new approach is designed to support inspection by specialist teams, through inspections which, rather than being focused on regulations, are based on identifying lines of enquiry from whatever quantitative and qualitative information suggest about standards of care.</p> <p>The Care Quality Commission's new approach to monitoring the quality and safety of services has been introduced initially in acute hospitals. New Chief Inspectors of General Practice and of Adult Social Care took up post in October 2013, and will now spearhead the extension and development of new approaches to monitoring and inspecting standards of care in those sectors. The Deputy Chief Inspector of Mental Health will report to the Chief Inspector of Hospitals on how this applies to mental health services.</p>	<p>As described in recommendation 38, the Care Quality Commission started piloting its new inspection regime in September 2013 and has been steadily rolling this out to all health and care sectors. Care Quality Commission is now in the process of inspecting all NHS acute trusts using the new model of inspection</p>
51	The Care Quality Commission should develop a specialist cadre of inspectors by through training in the principles of hospital care.	<p>Accepted.</p> <p>The Chief Inspector of Hospitals has begun inspecting in this way. Useful lessons</p>	<p>In January 2014, the Care Quality Commission started its new inspection programme for mental health trusts, community trusts and general practice out of hours services. In April 2014, the first new style inspections started in adult</p>

	<p>Inspections of NHS hospital care providers should be led by such inspectors who should have the support of a team, including service level 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.</p>	<p>were learnt from the Care Quality Commission's targeted inspections of 150 learning disability in-patient units following events at Winterbourne View hospital; these benefitted enormously from the involvement in inspection of trained and supported learning disabled self-advocates and family carers.</p> <p>Also, building on the approach developed by Professor Sir Bruce Keogh's reviews of mortality in 14 NHS trusts, the Chief Inspector of Hospitals has started inspections involving teams made up of senior and junior doctors, nurses and allied health professionals; senior managers; and people with experience of using hospital services. Six thousand individuals put themselves forward to be part of these inspections, and the number continues to increase. This is encouraging progress towards ensuring that inspection teams with a range of specialist and lay perspectives will be sustainable.</p> <p>Through its Chief Inspector of Hospitals, the Care Quality Commission will extend this approach to mental health, community healthcare and ambulance services during 2014–15, with appropriate adaptation and tailoring to those sectors. The approach will be adapted to independent as well as NHS providers.</p> <p>New Chief Inspectors of General Practice and of Adult Social Care took up post in October 2013, and will similarly spearhead the extension and development of new approaches to monitoring and inspecting standards of care in those sectors.</p>	<p>social care. The Care Quality Commission's rating of providers will commence in Independent Mental Health (community and hospitals), NHS Specialist Acute Hospitals and NHS Ambulance Trusts is expected to start in early 2015.</p>
52	<p>The Care Quality Commission should consider whether inspections could be done in collaboration with other agencies, or whether they can take advantage of any peer review arrangements available.</p>	<p>Accepted.</p> <p>The Care Quality Commission is developing Memoranda of Understanding with medical, nursing and midwifery Royal Colleges. These will ensure that peer review and accreditation schemes are taken fully into account as new methods of inspection are introduced in each sector and evolve. The Care Quality Commission will continue joint inspection with other regulators and inspectorates. This will include extending from December 2013 the approach to coordination developed with the General Medical Council (see below), to other professional regulators.</p> <p>In <i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i> the Care Quality Commission consulted on new approaches to regulation and, as part of that, proposed closer work with other agencies and better use of accreditation and peer review schemes. On 17 October 2013, it published the responses to the consultation in <i>A new start: Responses to our consultation on changes to the way the Care Quality Commission regulates, inspects and monitors care services</i>, which showed that there is broad agreement with the new approach.</p> <p>The Care Quality Commission and the General Medical Council have explored coordination through shadowing each other's inspections and assessments of professional education; this is reflected in an <u>operational protocol</u> that they have published. Discussions are under way on how best to learn from this, and extend the learning to other professional regulators in healthcare.</p>	<p>Under the leadership of the Chief Inspectors, the Care Quality Commission has put in place specialist inspection teams that subject providers to greater scrutiny. Inspections now routinely involve expert inspectors and people with experience of receiving.</p> <p>The Care Quality Commission is currently undertaking work whether on it might take account of accreditation schemes in Adult Social Care. During May 2014, the Care Quality Commission held a series of roundtable events with stakeholders and also co-production sessions, which generated mixed views. As a consequence, the Care Quality Commission with its staff and stakeholders will be giving further consideration to accreditation.</p> <p>Memoranda of Understanding are being developed and revised with other strategic partner organisations, often supported by joint operating protocols. For example, a joint working protocol has recently been established with the Nursing and Midwifery Council and will be embedded in 2015. The Care Quality Commission is close to updating its joint working arrangements with the National Institute for Health and Care Excellence and the Health and Care Professionals Council, and the Care Quality Commission intelligence teams are liaising with the Health and Care Professionals Council on routine information sharing.</p> <p><u>General Medical Council /The Care Quality Commission protocol</u></p> <ul style="list-style-type: none"> • The General Medical Council and the Care Quality Commission reviewed their Joint Operating Protocol, and published the revised version on 11 December 2014. <p><u>Revalidation and General Medical Council/The Care Quality Commission joint training</u></p> <ul style="list-style-type: none"> • The Care Quality Commission has submitted their Annual Organisational Audit report • The Care Quality Commission is preparing a development plan to set up structure and processes for the Care Quality Commission as a designated body. • The Care Quality Commission is including questions about appraisal and revalidation in our GP inspections. • The Care Quality Commission is developing a process for working with Area Teams to discuss practice and individual performance prior to and

			<p>following inspections.</p> <ul style="list-style-type: none"> • A representative from the Care Quality Commission sits on the General Medical Council's Expert Advisory Group on Standards for Education and Training. The Care Quality Commission has introduced the concept of Key Lines of Enquiry to this group and this methodology is now being looked at in the creation of new standards. • An e-learning package is being developed – by agreement with the Chief Inspector for Primary Medical Services and Integrated Care, Professor Steve Field - and will be integrated into the Care Quality Commission's annual programme of GP training. <p><u>Data to support GP inspections:</u></p> <ul style="list-style-type: none"> • Internal discussions at the Care Quality Commission are underway to understand how the General Medical Council can provide information to support this process. <p><u>Data to support hospital inspections:</u></p> <p>The General Medical Council continues to send the Care Quality Commission sets of information relating to individual trusts, for use as part of our inspection process. The data covers each of their core functions: Registration & Revalidation, Fitness to Practise and Education.</p> <p>The General Medical Council also shares this information with the responsible officer at the trust.</p> <p><u>Information Sharing Agreement:</u></p> <p>Development of the Information Sharing Agreement and the individual sharing schedules therein has been progressing slowly, partly due to the development of the Care Quality Commission's new approach and data packs, but it is a priority and the Care Quality Commission is aiming to finalise this in the near future.</p>
53	<p>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.</p>	<p>Accepted.</p> <p>There are no plans to abolish the Care Quality Commission. The Care Quality Commission has set out a new strategy for the next three years, and has a new Board in place, with five new Non-executives and its three Chief Inspectors. The Care Quality Commission has begun a process of fundamental change, begun in the hospital sector and to be rolled out to the other services that it regulates.</p> <p>On 1 October 2013, the Secretary of State for Health announced the intention to give the Care Quality Commission greater independence. Under the proposals, the Secretary of State will relinquish a range of powers to intervene in the operational decisions of the Care Quality Commission. This means that the Care Quality Commission will no longer need to ask for Secretary of State approval to carry out an investigation into a hospital or care home. It will also remove the Secretary of State's power to direct the Care Quality Commission on the content of its annual report. The Government proposes to make these changes via the Care Bill, by amending the Health and Social Care Act 2008, under which the Care Quality Commission was established. The Care Bill will also put the Chief Inspectors' posts into statute to ensure their longevity.</p> <p>In April 2013 the Care Quality Commission published its future strategy document in <i>Raising Standards, putting people first – our strategy 2013–16</i>. In this it sets out how it will work better with partners in health and social care, build relationships with the public and those it regulates, and build a high performing organisation.</p> <p>A change programme is underway for the Care Quality Commission to develop into a strong, independent, expert inspectorate whose evidence based, professional judgements are welcomed and instructive. The Chair and Board is reviewing governance structures throughout the organisation to ensure that decisions are taken by the right people at the right time.</p> <p>In <i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i> the Care Quality Commission consulted a new approach to hospital</p>	<p>The Care Quality Commission has a programme of transformation focussed on developing its new regulatory approach, and on ensuring that the organisation is structured, skilled and supported to deliver this. Key elements in the overall transformation delivered since November 2013 include:</p> <ul style="list-style-type: none"> • The reorganisation of the Care Quality Commission's inspection workforce into three inspection directorates from April 2014, each led by a Chief Inspector; • New waves of inspections in adult social care, primary medical services, mental health and community health, which were rolled out from April 2014- with full rollout in the acute hospitals sector; • Provider handbooks published for all sectors; • Senior leadership and management posts competed for and largely filled; • The Scheme of Delegation changed to reflect the new structure and roles; • The Academy (for training and development) up and running delivering induction courses, training for new approach waves; • and a learning management system for staff on track to be live in autumn 2014. <p>In 2015, the Care Quality Commission will focus on i) developing and using an overarching operating model with supporting business processes to drive value for money into its approaches; ii) learning from its inspection waves and ensuring a sustainable approach; iii) transforming its registration approach; iv) implementing its new regulatory powers from the Care Act; v) relooking at its approach to handling and using complaints, concerns and whistle-blowing; and vi) embedding the changes made in 2013/14 to ensure they become and remain mainstream accountabilities.</p>

		<p>inspections. On 17 October 2013, it published the responses to the consultation, <i>A new start: Responses to our consultation on changes to the way the Care Quality Commission regulates, inspects and monitors care services</i>, which showed that there is broad agreement with the new approach. The new Chief Inspector of Hospitals is leading the new inspections which started in September 2013. Chief Inspectors of General Practice and Adult Social Care took up their posts in October 2013, and will similarly spearhead the extension and development of new approaches to monitoring and inspecting standards of care in those sectors.</p>	
54	<p>Where regulatory issues 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.</p>	<p>Accepted.</p> <p>The Care Quality Commission is implementing this recommendation by means of partnership agreements and operational protocols which include criteria to make and store a formal record of meetings. So far, these cover the Care Quality Commission's relationships with Monitor, the NHS Trust Development Authority, Healthwatch England and the General Medical Council. The Care Quality Commission will extend this approach to other stakeholders, foremost among which are the other professional regulators and the Ombudsmen.</p>	<p>The Care Quality Commission is the independent regulator of health and adult social care providers in England. The Government has put in place a series of measures to give it greater independence. These include the removal of a number of specific powers for the Secretary of State for Health to intervene in its day to day work, the appointment of three Chief Inspectors and a strengthened Board.</p> <p>The Care Quality Commission is currently developing a Memorandum of Understanding with the Local Government Ombudsman. This will be underpinned by an information sharing protocol which will set out the circumstances and the nature in which information will be shared between the two bodies, the frequency information will be shared and the use to which it will be put.</p> <p>Similarly, the Care Quality Commission is also developing a protocol for sharing information, including relevant emerging and urgent concerns, safeguarding issues and whistleblowing concerns with the Parliamentary and Health Services Ombudsman (this does not apply where the Parliamentary and Health Services Ombudsman may be investigating the Care Quality Commission).</p> <p>These agreements aim to enable each organisation to fulfil its regulatory and/or statutory duties and responsibilities proportionately and collaboratively.</p>
55	<p>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.</p>	<p>Accepted.</p> <p>The Care Quality Commission has begun implementing a new approach to inspection and enforcement that is fundamentally different. It has appointed chief inspectors to lead this new approach in each sector. Key means of assuring its effectiveness include the extensive consultation and engagement that has helped to shape it, and the appointment of a Chief Inspector of Hospitals who personally spearheads it, ensuring that it commands the support of the sector and the public.</p> <p>The Department of Health will consult on new regulations which will come into effect during 2014. Subject to Parliamentary approval, these will set out clearly the fundamental standards below which care should never fall, and enable the Care Quality Commission to enforce against these standards without issuing a prior warning notice. The Care Quality Commission will consult on a new enforcement policy for all sectors (to sit alongside the failure regime for the NHS) so that these new regulations can be enforced effectively as they come into effect.</p> <p>Chief Inspectors of General Practice and Adult Social Care have been appointed, who will now start a similar process of consultation and engagement on new regulatory approaches for their sectors.</p> <p>An independent evaluation of the Care Quality Commission's new approach to hospital inspections has been commissioned from the King's Fund and Manchester Business School, and work began in October 2013. This will evaluate the</p>	<p>The Care Quality Commission has put in place arrangements to evaluate its new approach to inspection and regulation. It has engaged Frontier Economics to undertake a review of its operations, enabling the Care Quality Commission to understand and demonstrate to its stakeholders the ongoing impact of the Care Quality Commission regulation; and to assess its value for money. The Care Quality Commission has commissioned Frontier Economics to develop a robust framework for assessing the costs and benefits of regulation. This is part of a wider programme of related work being undertaken by the Care Quality Commission. The next steps for this project are for Frontier Economics to continue to gather and analyse data and evidence, both from the Care Quality Commission and more widely, including:</p> <ul style="list-style-type: none"> ● Total costs and the Care Quality Commission's funding ● Timesheet data and activity recording tool - to a varying degree of accuracy and completeness (varies across sectors and whether the Care Quality Commission – both direct staff or indirect - or external staff are concerned) ● Resource modelling for the new regulatory approach (typical made up of inspections, lengths of inspection, datapacks prepared, time spent writing up inspection reports, etc.) ● Scheduling Project – national scheduling tool for inspections ● Costs of inspections - (salaries of inspectors, day rates of experts by experience and other specialists, indirect costs such as travel & subsistence costs or printing costs, overhead costs such as intelligent monitoring, admin support, other corporate services and

		<p>effectiveness and efficiency of the new inspection model, and how inspection teams have used and acted upon the available surveillance information. The report of this evaluation will be published in May 2014.</p> <p>The Care Quality Commission is also developing a set of new strategic measures, which from 2014 will be reported in its quarterly performance reports to the Board and in its monthly scorecards on the Care Quality Commission website. These measures will include: how quickly it has responded to risks identified through the surveillance model; the proportion of providers judged to be poor, but for whom no risk information had been available; and the impact of action taken when providers have been judged to be poor or requiring improvement.</p>	<p>executive team) and other activities carried out by the Care Quality Commission for the new and old model</p> <ul style="list-style-type: none"> • Impact assessments – data and analysis therein <p>Frontier Economics have acknowledged that the Care Quality Commission operates in a complex and changing environment which makes it more difficult to attribute any change in final outcomes to the existence of the Care Quality Commission, however the project hopes to demonstrate the impact of the Care Quality Commission on service users and providers.</p> <p>The Care Quality Commission also commissioned the Manchester Business School (Kieran Walshe and Denham Phipps) to investigate how evidence and research can be used by the Care Quality Commission to evaluate how well its current regulatory arrangements in health and social care work. The findings of this report supported the restructure of the Care Quality Commission into sectoral based directorates and demonstrated the need for specialisation amongst inspectors. It also drove the development of the Care Quality Commission's standards and ratings framework.</p> <p>The Care Quality Commission also now has a programme board which monitors six internal projects, including:</p> <ul style="list-style-type: none"> • The Care Quality Commission's operating model • Quality framework • National scheduling • Cost of delivery • Value for money • Evaluation and benefits
56	<p>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.</p>	<p>Accepted.</p> <p>In April 2013 the Care Quality Commission published its new three year strategy, <u><i>Raising Standards, putting people first – our strategy 2013–16</i></u>. This document sets out how the Care Quality Commission will make major changes to what it does and how it does it.</p> <p>This was reinforced in June 2013, when the Care Quality Commission issued <u><i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i></u> to start the public discussion on what the fundamental standards of care should be and how surveillance, inspection and monitoring might work. On 17 October 2013, it published the responses to the consultation <u><i>A new start: Responses to our consultation on changes to the way the Care Quality Commission regulates, inspects and monitors care services</i></u>, which showed that there is broad agreement with the new approach.</p> <p>Chief Inspectors of Hospitals, General Practice and Adult Social Care have been appointed and will start a similar process of consultation and engagement on new regulatory approaches for their sectors. The Deputy Chief Inspector of Mental Health will report to the Chief Inspector of Hospitals on how they apply to mental health services.</p>	<p>Between 9 April and 4 June 2014 the Care Quality Commission consulted on how it planned to change the way it regulates, inspects and rate care services. The changes include things like:</p> <ul style="list-style-type: none"> • what the Care Quality Commission look at on an inspection. • how the Care Quality Commission judge what 'good' care looks like. • how the Care Quality Commission rate care services to help people judge and choose care if they want to. • how the Care Quality Commission use information to help decide when and where to inspect. <p>The Care Quality Commission has published consultation handbooks for seven services and consulted on enforcing the fundamental standards. More information is provided in response to recommendation 14.</p> <p>In July 2014, the Care Quality Commission published a <u>consultation</u> on guidance for providers meeting the fundamental standards and on the Care Quality Commission's enforcement powers.</p> <p>The consultation closed on 17 October 2014. The Care Quality Commission is considering the responses and will publish its new guidance ahead of the regulations coming into force in April 2015</p> <p>As part of its 2014-15 business plan the Care Quality Commission has published details of how it will measure its impact, outcomes, quality, effectiveness and internal capabilities. See response to recommendation 55.</p>
57	<p>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</p>	<p>Accepted.</p> <p>The Care Quality Commission has carried out a significant review of how it uses information to identify potential failures in the quality of care in hospitals. Taking each</p>	<p>The Care Quality Commission has put in place a system of Intelligent Monitoring to help decide when, where and what to inspect. This draws information and data from a range of sources to identify providers and services where there may be a greater risk of providing poor care. The evidence from the Intelligent</p>

	<p>the Trust described in this report, and in the report of the first inquiry, and open that evaluation for public scrutiny.</p>	<p>of five key questions – is a service safe, effective, caring, responsive and well led – the review undertook to define an ‘ideal’ set of indicators that the Care Quality Commission could routinely monitor to identify these potential failures. The review then scoured national and international best sources in quality measurement. A short list of potential measures was then identified and tested through analysis and a series of engagements with the sector and experts in the measurement of quality. In <u><i>A new start – Consultation on changes to the way CQC regulates inspects and monitors care</i></u> the Care Quality Commission consulted on the set of indicators. It analysed the resulting set of indicators, and published on 24 October 2013 for the first time the analysis outputs, which it will publish quarterly. This way it will ensure wider feedback on its approach. It is also committed to on-going evaluation of the indicators to learn and improve the new approach.</p>	<p>Monitoring system is used to prioritise which providers will be inspected and the lines of enquiry during an investigation. The system triggers a response, for example, where there are a statistically significant number of severe harm incidents or avoidable deaths at a provider. “Never events” trigger an automated elevated risk in Intelligent Monitoring which inspectors follow up individually. The data it looks at includes information from:</p> <ul style="list-style-type: none"> • Staff • Patient surveys • Mortality rates • Hospital performance information such as waiting times and infection rates <p>In October 2013 the Care Quality Commission began a pilot of its intelligent monitoring programme for acute and specialist NHS Trusts. The pilot looked at more than 150 different sets of data (indicators), which relate to the five key questions the Care Quality Commission asks of all services – are they safe, effective, caring, responsive, and well-led? Using this data, the Care Quality Commission grouped all acute NHS trusts into six priority bands for inspection (The bands are based on the likelihood that people may not be receiving safe, effective, high quality care). The Care Quality Commission completed its latest round of Intelligent Monitoring of trusts in July 2014.</p> <p>In November 2014, the Care Quality Commission published Mental Health intelligent monitoring reports, which display the results of its analysis of Tier 1 indicators for all Mental Health NHS trusts. Each trust will receive an individual report and banding, similar to those for acute hospitals. The bandings will range from one to four.</p> <p>In November 2014 the Care Quality Commission published its first round of Intelligent Monitoring for GPs</p> <p>Draft Intelligent Monitoring models for the Adult Social Care sector have been in place since October 2014, with separate sets of indicators for residential, community and hospice services. the Care Quality Commission will continue to develop these models with providers and stakeholders to develop a more robust Intelligent Monitoring system within Adult Social Care during 2015/16 and beyond</p>
58	<p>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.</p>	<p>Accepted.</p> <p>The Care Quality Commission uses a wide range of means to engage people who use services in its work. It is holding a number of events and activities to ask people how they it can best involve patients, relatives and carers in its work. This includes looking specifically at a ‘People’s Panel’</p> <p>Healthwatch England is the independent consumer champion for health and social care in England, and works closely with the Care Quality Commission. The Chair of Healthwatch England sits on the Care Quality Commission’s Board and is able to ensure a focus in the board’s considerations on the views of people who use health and care services.</p> <p>The Care Quality Commission engages directly with people who use health and social care services to consult on its strategy and policy activity, as well as involving people who use services in the development of its regulatory methodologies. It also recruits, trains and supports people who use services to accompany its inspection staff on inspections (these people are known as ‘Experts by Experience’); the benefits of involving learning disabled Experts by Experience in the post-Winterbourne View hospital inspections of learning disability in-patient units were very clear. The Care Quality Commission works at a local level with overview and scrutiny committees, and Foundation Trust councils of governors, who scrutinise the different elements of the local system, to share information</p>	<p>The Care Quality Commission recruits, trains and supports people who use services- known as ‘Experts by Experience’- to accompany its inspection staff on inspections of health and social care services and its visits to monitor the use of the Mental Health Act.</p> <p>Experts by Experience also attend listening events, consultations and staff training events and take part in activities to develop the Care Quality Commission’s strategy and processes. The Care Quality Commission currently works with around 500 Experts by Experience covering a wide variety of backgrounds.</p> <p>During inspections, Experts by Experience spend time talking to people who use the service and observing the environment. They have first-hand experience of receiving care so they know which questions to ask to get as much information from the visit as possible. Their findings are used to support the inspector’s judgment on the service and can also be included in the inspection report.</p> <p>The Care Quality Commission has received a huge amount of applications to be an Expert by Experience and have currently paused recruitment. However, the Care Quality Commission has developed an online community that people can be a part of, called the Care Quality Commission Action Team. People who are members of the Care Quality Commission’s Action Team help the Care Quality Commission to develop our policies, processes and inspection materials. The Care Quality Commission Action Team members also receive a monthly news</p>

		<p>about the safety and quality of local services. The Care Quality Commission works with local Healthwatch and other local voluntary and community organisations, to share surveillance and intelligence to support the Commission's regulatory function.</p>	<p>update which lets them know how to get involved in the Care Quality Commission activities and the promotion of listening events.</p>
59	<p>Consideration should be given to the introduction of a category for 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.</p>	<p>Accepted in principle</p> <p>Steps have already been taken by Care Quality Commission to establish a series of sector specific advisory groups, which include senior representatives from Royal Colleges and patient groups. These groups support the three new Chief Inspectors by:</p> <ul style="list-style-type: none"> contributing to the design and development of methods and approaches by providing expert advice, opinion and challenge; providing a steer on any issues arising; acting as an advocate for the Care Quality Commission and as a communication channel to their 'community/membership', helping to share the understanding, seek wider input; recommending individuals to join task and finish groups, to provide expert knowledge and advice on detailed areas of work, such as the drafting of guidance. <p>In September 2013 the Care Quality Commission also appointed a National Advisor on Patient Safety, Culture and Quality.</p> <p>The Care Quality Commission is also considering whether this recommendation could provide a renewed impetus to its Advisory Committee as a statutory, advisory body to the Board in order to ensure that different perspectives on quality and safety of care are all taken into account.</p> <p>In addition, Since publication of the Inquiry report, the Care Quality Commission has appointed a new Board of executive and non-executive directors. The three new Chief Inspectors have been appointed to the Board; they provide leadership to ensure that hospital, social care and primary care perspectives are fully taken into account. A strong voice for people who use health and care services is provided by the Chair of Healthwatch England. The Care Quality Commission, in particular through the Chief Inspectors, also has close links to the Royal Colleges through a sector-specific advisory committee. It has also set out a strategy which commits it to ensuring that providers, professionals and people who use health or care services will help shape the approach to regulation.</p>	<p>All of the Care Quality Commission's new style inspections involve healthcare professionals as part of the inspection teams, according to their areas of specialism and training and depending on the service being inspected. In addition to this many of the Care Quality Commission's inspectors themselves come from specialist health backgrounds and are working in the sector in which they trained. For example, the Care Quality Commission inspectors who are clinical scientists and radiographers by training inspect radiology facilities and departments, both as individual inspections and as part of broader hospital inspections, providing specialist insight. The Care Quality Commission's Chief Inspectors of Hospitals, Adult Social Care and General Practice themselves have significant experience and expertise in their sectors, as well as a number of their Deputy Chief Inspectors.</p> <p>The Care Quality Commission has been working with healthcare professionals including the Royal Colleges and their faculties, as well as providers, the public and other stakeholders throughout the development of its new regulatory approach. This has included:</p> <ul style="list-style-type: none"> Engagement in the development of the Care Quality Commission's new approach to monitoring, inspecting and rating services and guidance on new regulations and enforcement powers Identification of healthcare professionals to participate in the Care Quality Commission's inspections Support for the Care Quality Commission's work on the use of clinical service accreditation schemes Commitment to working together through the development of memoranda of understanding, joint working statements and information sharing agreements
60	<p>The Secretary of State should consider transferring the functions of regulating the governance of healthcare providers and the fitness of persons to be directors, governors or equivalent persons from Monitor to the Care Quality Commission.</p>	<p>Accepted in principle.</p> <p>However, we believe that the best way to achieve the desired outcome is through closer co-operation between Monitor and the Care Quality Commission rather than through the transfer of functions. The Care Quality Commission's inspection regime will include a focus on whether or not an organisation is 'well-led'.</p> <p>We agree that the public have the right to expect that people in leading positions in NHS organisations are fit and proper persons; and that where it is demonstrated that a person is not fit and proper, they should not be able to occupy such a position. Monitor and the Care Quality Commission are committed to ensuring that, taken together, their processes for registration and licensing reflect these principles. The Care Quality Commission's inspection regime will include a focus on whether or not an organisation is 'well-led'.</p>	<p>The NHS Trust Development Authority, Monitor and the Care Quality Commission published <i>How Monitor, the Care Quality Commission and the NHS Trust Development Authority will work together to assess how well led organisations are</i> in May 2014.</p> <p>The Department of Health has consulted on a new registration requirement that all directors of providers registered with the Care Quality Commission must meet a fit and proper person test. The Care Quality Commission will be able to insist on the removal of directors that fail this test. The consultation included how the revised fit and proper person requirement will work, and questions about the impact of the new regulations. The <u>consultation</u> ran from 27 March to 25 April 2014. The Fit and Proper Persons Test Regulations have been passed by Parliament and are in place in November 2014 for NHS organisations and from April 2015 for other organisations.</p>

		<p>In order to support this, the Government issued in July 2013 a consultation on <i>Strengthening corporate accountability in health and social care</i>. This proposes a new requirement that all Board Directors (or equivalents) of providers registered with the Care Quality Commission must meet a new fitness test. We are proposing that this test includes checks about whether the person is of good character including past employment history, and if the individual has the qualifications, skills and experience necessary for the work or office as well as the more traditional consideration of criminal and financial matters.</p> <p>The Government proposes that the fit and proper persons test will now be used as a mechanism for introducing a scheme for barring Directors who are unfit from individual posts by Care Quality Commission at the point of registration. Where a Director is considered by Care Quality Commission to be unfit it could either refuse registration, in the case of a new provider, or require the removal of the Director on inspection, or following notification of a new appointment. Further details will be set out in the response to the consultation on corporate accountability which will be published shortly. We plan to publish the draft regulations for consultation at the same time.</p> <p>See also recommendations 79 and 80.</p>	
61	<p>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.</p>	<p>Not accepted, although we agree with the principle regarding changes to the regulatory system.</p> <p>While we do not accept this recommendation in the light of the response to recommendation 19, we agree with the principles that it outlines regarding changes to the regulatory system. If changes are required between regulatory functions, they should be considered carefully and implemented appropriately to ensure that the organisational memory is retained and that, where change is needed, it is undertaken after appropriate consultation.</p> <p>However, as outlined in relation to recommendation 19, we do not intend to merge regulatory functions through the development of a single regulator. Rather we intend to implement a single failure regime with clear roles and responsibilities, keeping separate the responsibility for inspecting and assessing quality from the responsibility for improvement.</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths.</p>
62	<p>For as long as it retains responsibility for the regulation of FTs, Monitor should incorporate greater patient and public involvement into its own structures, to ensure this focus is always at the forefront of this work.</p>	<p>Accepted.</p> <p>A central theme of Monitor's Quality Governance Framework is whether the Boards of NHS organisations actively engage patients, staff and other key stakeholders on quality. From April 2013 it is also a licence condition that Foundation Trusts actively engage with patients on the quality of care and take into account their views. Monitor's assessment process includes reviews of patient surveys and the NHS staff survey, meetings with staff and patient groups, review of access and outcome metrics, local media coverage and interviews with lead commissioners, the Care Quality Commission and external and internal auditors. Monitor also writes to local MPs and Healthwatch to see if they have any concerns they wish to raise. As part of Monitor's Quality Governance review they seek to understand the Trust Board's arrangements to actively engage with patients. Levels of service performance and standards of care quality form part of Monitor's regular risk assessment of Foundation Trusts including the Care Quality Commission's judgements on the quality of care provided. Monitor also expects licence holders to notify them in the event of any incident, event or report that may raise potential concerns over compliance with the licence. Regulatory action may also be triggered by information from local patient groups if it represents a material concern. This is underpinned by two-way sharing of information on patient complaints by Monitor and Care Quality Commission and sharing of intelligence on the quality of care by regional and local Quality Surveillance Groups. Where</p>	<p>Monitor appointed Hugo Mascie-Taylor as Medical Director and Director of Patient and Clinical Engagement in May 2014. A good practice toolkit to guide Monitor's patient engagement has also been developed and a patient awareness programme undertaken including an all staff event on making a difference for patients. 'Patients first' is now one of Monitor's five values and further work is planned to embed the values into Monitor's everyday work.</p>

		<p>enforcement action is required further intelligence may be sought including seeking the views of patient representatives and undertaking further analysis of the complaints made to the Foundation Trust, Monitor and Care Quality Commission.</p> <p>To further embed patient involvement in Monitor's processes, Monitor is currently engaging with the Department of Health on the recruitment of a Medical Advisor and Director of Patient and Clinical Engagement, and has developed three patient engagement work strands which will be taken forward over the next 12 months.</p> <p>Projects are underway working with a social research consultancy, patient representative bodies, Healthwatch and other national level health organisations, to help Monitor better understand what good practice looks like when engaging and consulting with patients, the public and their representatives.</p> <p>Monitor has also pledged to build the use of patient intelligence and complaints into their regulatory approach, working closely with the Care Quality Commission, and will put in place a plan to ensure that 'patients first' is embedded into its culture and ways of working.</p>	
63	<p>Monitor should publish all side letters and any rating issued to trusts as part of their authorisation or licence.</p>	<p>Accepted.</p> <p>Monitor has published all side letters since 2011 and risk ratings are published on a quarterly basis. Side letters are issued in certain circumstances where an applicant meets the statutory requirements for authorisation but there are matters that need to be addressed within a specified timeframe. The letter will detail the issue that needs to be addressed and the monitoring arrangements to be put in place to ensure delivery.</p> <p>The welcome letter to a newly authorised trust sets out risk ratings for the first year. The quarterly risk rating is published on Monitor's web-site in the first quarter following authorisation. Monitor's risk-based framework assigns risk ratings to each NHS Foundation Trust on the basis of its forward plan and in-year performance against that plan. Monitor uses these ratings to guide the intensity of monitoring and to signal Monitor's degree of concern with specific issues identified, and consequently the risk of breach of the Continuity of Services or governance conditions of the licence.</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>
64	<p>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.</p>	<p>Not accepted, although we agree with the principle of better regulation of the authorisation process.</p> <p>As outlined in relation to recommendation 19, we agree with the principle of better regulation of the authorisation process, but we do not intend to merge regulatory functions. What is needed is radically better coordination between the regulators, and a far stronger focus on the quality and safety of services within the authorisation process, than was the case at Mid Staffordshire NHS Trust.</p> <p>The Department of Health, with the Care Quality Commission's chief inspectors, is currently developing fundamental standards and will consult on setting these out in regulations, which make clear the standards below which care should never fall. A provider who is in breach of fundamental standards should not be authorised as a Foundation Trust.</p> <p>As set out in recommendation 20, the Care Quality Commission's new approach to inspection will look more broadly than just compliance with regulations. It will reach judgements about the overall quality of services, taking into account how safe, effective, caring, responsive and well-led they are. No provider will be authorised as a Foundation Trust unless the Care Quality Commission, through its Chief Inspector of Hospitals, judges that the quality of their services is 'good' or 'outstanding'.</p> <p>The NHS Trust Development Authority, Monitor and the Care Quality Commission</p>	<p>The NHS Trust Development Authority, Monitor and the Care Quality Commission published <i>How Monitor, the Care Quality Commission and the NHS Trust Development Authority will work together to assess how well led organisations are</i> in May 2014.</p> <p>The metrics by which the NHS Trust Development Authority will assess the quality of services delivered by any given Trusts, which are set out in the NHS Trust Development Authority Accountability Framework for NHS Trusts, are consistent with those used by the Care Quality Commission in its Intelligent Monitoring system.</p>

		<p>have undertaken an end-to-end review of the Foundation Trust assessment and authorisation process. The review aligns Monitor's Quality Governance Framework with the Care Quality Commission's approach to assessing leadership, culture and governance as part of the new inspection methodology. Monitor, the NHS Trust Development Authority and the Care Quality Commission will also develop a common set of quality indicators. This should ensure that there is a seamless process at every stage of assessment.</p>	
65	<p>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.</p>	<p>Accepted.</p> <p>The NHS Trust Development Authority has published its Accountability Framework which sets out how Trusts will be held to account for delivering the appropriate quality of care. Trusts which are failing to meet these standards are subject to a robust and transparent escalation process.</p>	<p>Since the decision was made only to support Foundation Trust applications from providers with a Care Quality Commission rating of 'good' or 'outstanding', the NHS Trust Development Authority has advised the Care Quality Commission on trusts that should be considered as priorities for inspection in order to allow their Foundation Trust bids to progress. 55 NHS Trusts have been inspected under the new arrangements, and of these ten have received NHS Trust Development Authority board approval to be considered by Monitor for Foundation Trust authorisation.</p>
66	<p>The Department of Health, the NHS Trust Development Authority and Monitor should jointly review the stakeholder consultation process with a view to ensuring that;</p> <ul style="list-style-type: none"> 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. 	<p>Accepted.</p> <p>The NHS Trust Development Authority will test Trusts' Patient and Public Involvement strategies to ensure they are engaging with their patients and local community throughout the Foundation Trust application process, particularly on the quality of care being provided. It will also verify that Trusts are explicitly asking questions about quality of care in their public consultation and triangulating responses with any identified issues of clinical quality.</p> <p>The NHS Trust Development Authority will follow up with the Trust on what it has done in response to any concerns raised during the consultation process and record this feedback, sharing the information with Monitor as necessary throughout the application process.</p> <p>Monitor's assessment process also includes reviews of patient views and the NHS staff survey, meetings with staff and patient groups, review of access and outcome metrics, local media coverage and interviews with lead commissioners, the Care Quality Commission and external and internal auditors. Monitor also writes to local MPs and Healthwatch to see if they have any concerns they wish to raise. As part of their Quality Governance review they also seek to understand the Trust board's arrangements to actively engage with patients. Monitor will continue to consider the content of the consultation and the applicant's response to the issues raised as part of the assessment process.</p>	<p>As set out in the NHS Trust Development Authority Accountability Framework for NHS Trusts, Trusts must demonstrate that they have sought feedback from the public regarding the quality of their services, and that this feedback is being used to make the necessary improvements.</p>
67	<p>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.</p>	<p>Accepted.</p> <p>The focus of the NHS Trust Development Authority is to enable NHS Trusts to provide high quality, sustainable services for their local communities. It does this by overseeing all aspects of a Trust Board's performance on delivering high quality care and supporting them to become sustainable organisations, thereby preparing them to become a Foundation Trust. The Board of the NHS Trust Development Authority will only approve a Trust's application to be passed to Monitor, when it is satisfied that the Trust has clearly demonstrated both these aspects.</p> <p>The NHS Trust Development Authority has set out its rigorous process for assessing aspirant Foundation Trusts in its Accountability Framework <i>Delivering High Quality Care For All</i>. There will be a comprehensive inspection by the Care Quality Commission of the quality of services delivered by an aspirant Foundation Trust, as well as the quality governance arrangements within a Trust, prior to any decision by the Board of the NHS Trust Development Authority as to whether a Foundation Trust application will be supported. No provider will go forward for Foundation Trust authorisation unless the Care Quality Commission, through its Chief Inspector of</p>	<p>NHS Trusts are now required to produce 5-year strategic plans. Trusts will only have their Foundation Trust applications approved by the NHS Trust Development Authority Board if they are able to demonstrate their sustainability in the long-term, as well as achieving a 'good' or 'outstanding' rating.</p>

		Hospitals, judges that the quality of their services is 'good' or 'outstanding'.	
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.	<p>Accepted.</p> <p>The Board of the NHS Trust Development Authority will only approve a Trust's application to be passed to Monitor, when it is satisfied that the Trust has clearly demonstrated that it is able to provide high quality care for patients, and has the right business plan in place to ensure it can continue to deliver well into the future.</p> <p>The NHS Trust Development Authority has set out its rigorous process for assessing aspirant Foundation Trusts in its Accountability Framework, <i>Delivering High Quality Care For All</i>, of which the quality and sustainability of services is the focus. The NHS Trust Development Authority considers information from the public consultation, the Care Quality Commission, NHS England, the relevant Clinical Commissioning Group(s) and other national and local system partners prior to the NHS Trust Development Authority Board making a decision as to whether a Foundation Trust application will be supported. No provider will go forward for Foundation Trust authorisation unless the Care Quality Commission, through its Chief Inspector of Hospitals, judges that the quality of their services is 'good' or 'outstanding'.</p>	No further update is required. Please see response to the recommendation in Hard Truths
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.	<p>Accepted.</p> <p>The NHS Trust Development Authority has set out its rigorous process for assessing aspirant Foundation Trusts in its Accountability Framework <i>Delivering High Quality Care For All</i>. Quality and sustainability are the focus of the Foundation Trust application approvals process.</p> <p>This involves a comprehensive inspection by the Care Quality Commission of the quality of services delivered by an aspirant Foundation Trust, as well as the quality governance arrangements within a Trust, prior to any decision by the Board of the NHS Trust Development Authority as to whether a Foundation Trust application will be supported.</p> <p>Trusts are challenged throughout Monitor's assessment process to demonstrate that they meet all of the assessment criteria relating to quality and safety. A number of changes in relation to providing evidence of quality have already been implemented to strengthen this (see recommendations 62 and 66 for details), and in particular NHS Trusts who aspire to become Foundation Trusts will in future no longer be able to do so unless and until they have achieved a 'good' or an 'outstanding' rating under the new Care Quality Commission inspection regime.</p> <p>A joint working group between Monitor, the Care Quality Commission and NHS Trust Development Authority has been formed to ensure that the process for assessing applicant trusts reflects the recommendations of the Inquiry. This work is intended to strengthen further the assessment of quality in the approvals process through better sharing of information and expertise, alignment of metrics and ensuring more consistent judgements on quality.</p>	The 'end to end' review of the authorisation process is now complete and changes have been made to how quality is assessed in the process e.g. early quality governance review, NHS Trust Development Authority de-briefing meeting at the beginning of assessment and a revised threshold for referral to Monitor linked to the Care Quality Commission's rating.
70	A duty of utmost good faith should be imposed on applicants for Foundation Trust status to disclose to the regulator any significant information material to the application and to ensure that any information is complete and accurate. This duty should continue throughout the application process, and thereafter in relation to the monitoring of compliance.	<p>Accepted.</p> <p>NHS Trusts are expected to be open with the NHS Trust Development Authority and regulators throughout the Foundation Trust application process. In order to further support this duty of utmost good faith, the NHS Trust Development Authority will explicitly ask Trusts if they have anything to declare in relation to their application in the final Board-to-Board meeting before it is formally considered by the board of the NHS Trust Development Authority for approval to proceed to Monitor.</p> <p>The Care Quality Commission is working closely with both Monitor and the NHS</p>	No further update is required. Please see response to the recommendation in Hard Truths

		<p>Trust Development Authority to ensure that all applicants are subject to inspection so that comprehensive, up-to-date information on the quality of care and governance process is available at the appropriate stages of the application process, and prior to any decision by the board of the NHS Trust Development Authority as to whether a Foundation Trust application will be supported. Monitor also now requires all applicants to sign a letter to confirm that they have provided all information relevant and material to the Foundation Trust assessment process.</p> <p>The Care Quality Commission is also involving Monitor and NHS Trust Development Authority in developing its new inspection methods and surveillance model, so as to ensure that opportunities for information-sharing are identified and used fully on an on-going basis.</p> <p>In addition, as set out in recommendation 173, every healthcare organisation and everyone working for them must be honest, open and truthful. This will build upon the existing requirement of Monitor's licence that information provided is accurate, complete and not misleading and the expectation that licence-holders notify Monitor in the event of any incident, event or report that may raise concerns over compliance with their licence.</p>	
71	<p>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.</p>	<p>Accepted.</p> <p>The NHS Trust Development Authority's role is to ensure, on behalf of the Secretary of State for Health, that aspirant Foundation Trusts are ready to proceed for assessment by Monitor. This role is discharged on behalf of the Secretary of State by the Board of the NHS Trust Development Authority, which will not refer to Monitor any Trust where there are concerns relating to the compliance with any of the relevant standards either now or in the future. The decision of the Board is made with regard to the public consultation and after consulting with the Care Quality Commission, NHS England and other national and local system partners.</p> <p>No provider should be authorised as a Foundation Trusts unless the Care Quality Commission, through its Chief Inspector of Hospitals, judges that the quality of their services is 'good' or 'outstanding'.</p>	<p>NHS Trusts are now required to produce 5-year strategic plans. Trusts will only have their Foundation Trust applications approved by the NHS Trust Development Authority Board if they are able to demonstrate their sustainability in the long-term, as well as achieving a 'good' or 'outstanding' rating.</p>
72	<p>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.</p>	<p>Accepted.</p> <p>The Care Quality Commission has agreed that, in the future, it will inspect NHS Trusts while the NHS Trust Development Authority is assessing whether to support their Foundation Trust application to progress to Monitor. This inspection earlier in the process will provide invaluable information as to the applicant Trust's compliance with fundamental quality and safety standards. The Care Quality Commission's new inspection process is significantly more in-depth than its former approach and allows for large teams of specialist inspectors to visit any areas of a provider as they see fit.</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>
73	<p>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.</p>	<p>Accepted.</p> <p>As part of the normal accountability processes that the Department of Health has set in place as a sponsor, the state of the relationship between the Department and its arm's length bodies is kept under regular review. Discussions include key areas of risk, consideration of how well the Department and the relevant arm's length body are working together and what could be done to improve co-operation and shared understanding. These discussions also include consideration of how the arm's length body is working within the wider health and care system, including areas of significant uncertainty or concern in relation to other arm's length bodies.</p>	<p>The normal accountability processes that the Department of Health has set in place as a sponsor continue to address this recommendation.</p>
74	<p>Monitor and the Care Quality Commission should publish guidance for governors</p>	<p>Accepted.</p>	<p>In March 2014 Monitor published '<i>Your duties: a brief guide for NHS foundation trust governors</i>' which sets out the role of Monitor and Care Quality</p>

	<p>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.</p>	<p>Monitor published a number of guidance documents for Foundation Trust governors, most recently (August 2013) a revised version of <i>Your statutory duties: a guide for NHS Foundation Trust Governors</i>. This includes guidance on the new statutory duties from the <i>Health and Social Care Act 2012</i>, including that of representing the interests of members and of the public. This guidance has been published in association with the Department of Health, Care Quality Commission, Foundation Trust Network and Foundation Trust Governors Association.</p> <p>Working in partnership with Monitor and the Foundation Trust Network, the NHS Leadership Academy has commissioned the GovernWell Programme, a new national training programme for Foundation Trust governors. The GovernWell programme is designed to help equip governors and non-executives with the skills they need to perform effectively, including improving their ability to challenge quality problems.</p> <p>Monitor has also set up the Panel for Advising Governors, which has a former Foundation Trust chair as its Chair, together with 16 other experienced Members. The Panel has been operational since May 2013 and is ready to take questions from governors on topics as per the <i>Health and Social Care Act 2012</i>.</p> <p>Monitor, the Department of Health, Care Quality Commission, Foundation Trust Network and Foundation Trust Governors Association have agreed to publish jointly a summary guide for all Councils of Governors on the respective roles of the sponsoring organisations, how they work together and how they work with Governors, by the end of December 2013.</p> <p>Following this, the group is planning a series of good practice guides on key aspects of the governor role. The first of these guides is planned to be on representing the interests of members and the public, and is intended also to guide Foundation Trusts on how they will need to support governors in this aspect of their role.</p>	<p>Commission and also reminds governors of their legal responsibility to represent the interests of the public and members of the Foundation Trust. Work is also in hand to produce material to assist governors in representing the interests of the public. This guide is being produced with Monitor and NHS Providers and will be published shortly</p>
75	<p>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.</p>	<p>Accepted in part.</p> <p>In August 2013 Monitor published a revised version of <i>Your statutory duties: a guide for NHS Foundation Trust Governors</i> which includes guidance on the new statutory duties from the <i>Health and Social Care Act 2012</i>. This guidance has been published in association with the Department of Health, Care Quality Commission, Foundation Trust Network and Foundation Trust Governors Association.</p> <p>The above organisations recognise the variety of non-statutory duties that governors may perform, as well as the importance of preserving the autonomy of individual trusts and therefore the guidance does not seek to prescribe how governors should work day-to-day; NHS Foundation Trust boards and governors will agree this between themselves. Monitor and the Care Quality Commission will not review the descriptions produced by each Foundation Trust agreed between boards and governors.</p> <p>Monitor, the Department, Care Quality Commission, Foundation Trust Network and Foundation Trust Governors Association are planning a series of good practice guides to support governors in carrying out their duties. The first of these guides is planned to be on representing the interests of members and the public. In addition, Monitor, the Foundation Trust Network and the NHS Leadership Academy have commissioned the GovernWell programme, a new national training programme for Foundation Trust governors designed to help equip governors and non-executives with the skills they need to perform effectively.</p>	<p>In March 2014 Monitor published '<u><i>Your duties: a brief guide for NHS foundation trust governors</i></u>' which sets out the role of Monitor and Care Quality Commission and also reminds governors of their legal responsibility to represent the interests of the public and members of the Foundation Trust. Work is also in hand to produce material to assist governors in representing the interests of the public. This guide is being produced with Monitor and NHS Providers and will be published shortly.</p> <p>The GovernWell national training programme for foundation trust governors was launched in May 2013. GovernWell is a four tier programme that offers pre-induction resources, an induction toolkit, and core and specialist skills modules. Each tier of the programme builds on the last, offering governors the opportunity to build their knowledge and skill base to effectively operate in the role.</p>
76	<p>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</p>	<p>Accepted.</p> <p>The <i>Health and Social Care Act 2012</i> provides that one of the general duties of the Council of Governors is to represent the interests of the members of the corporation</p>	<p>In March 2014 Monitor published '<u><i>Your duties: a brief guide for NHS foundation trust governors</i></u>' which sets out the role of Monitor and Care Quality Commission and also reminds governors of their legal responsibility to represent the interests of the public and members of the Foundation Trust.</p>

	<p>constructive contact between governors and the public is maintained.</p>	<p>as a whole and the interest of the public. Governors are elected from the membership of the Foundation Trust, who in turn consist of staff members, the general public and sometimes, patients or service users and their carers.</p> <p>How governors engage and represent the public is not defined in law, as Foundation Trust boards and governors will agree between themselves how governors should work day-to-day. Examples of methods by which governors may represent the interests of the public are included in Chapter 4 of Monitor's publication <i>Your statutory duties: a reference guide for NHS Foundation Trust governors</i> (Aug 2013).</p> <p>Monitor, Department of Health, Care Quality Commission, Foundation Trust Network and Foundation Trust Governors Association are planning a series of good practice guides to support governors in carrying out their duties. The first of these guides is planned to be on representing the interests of members and the public.</p>	<p>Work is also in hand to produce material to assist governors in representing the interests of the public. This guide is being produced with Monitor and NHS Providers and will be published shortly</p>
77	<p>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.</p>	<p>Accepted.</p> <p>Working in partnership with Monitor and the Foundation Trust Network, the NHS Leadership Academy has commissioned the GovernWell programme, a new national training programme for Foundation Trust governors. The GovernWell programme is designed to help equip governors and non-executives with the skills they need to perform effectively, including improving their ability to challenge quality problems.</p> <p>Monitor has surveyed Foundation Trust governors to review the current levels of support available and shares good practice with Foundation Trust Chairs, chief Executives and non-executive Directors on working effectively with their governors. Monitor also speaks regularly to Trust staff and councils of governors on the role of governors and what the expectations should be of it.</p> <p>Monitor will be reviewing the uptake and feedback on the GovernWell programme on an ongoing basis. Monitor will also be supporting events hosted by the Foundation Trust Network for NHS Trust and Foundation Trust Chairs on working effectively with governors.</p> <p>Monitor will update the Code of Governance to reflect the statutory duty of Foundation Trust boards to provide appropriate training for Foundation Trust governors. Foundation Trust boards will also be asked to self-certify on this as part of the Annual Plan Review.</p>	<p>Monitor sits on the GovernWell Advisory Group, together with representatives from the former Foundation Trust Governors Association, the Department of Health, the NHS Leadership Academy and some chairs and trust secretaries from NHS Foundation Trusts. This group meets approximately quarterly to review the uptake and marketing of the programme and to discuss how best to refresh its content in the light of evolving governor needs.</p> <p>Monitor published a revised Code of Governance for Foundation Trusts in July 2014 and this references <i>Your statutory duties: a guide for NHS Foundation Trust Governors</i> as setting out the detailed governance requirements relating to governors. The detailed guide sets out the trust's duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.</p>
78	<p>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.</p>	<p>Accepted.</p> <p>Monitor has set up the Panel for Advising Governors, which has a former Foundation Trust chair as its Chair, together with 16 other experienced members. The panel has been operational since May 2013 and is ready to take questions from governors on topics as per the <i>Health and Social Care Act 2012</i>.</p> <p>Governors may therefore put a question to the existing panel on a breach or potential breach of the trust's constitution, breach of licence or any other matter under chapter 5 of the <i>National Health Service Act 2006</i>.</p> <p>The Care Quality Commission has recently written to all Councils of Governors to confirm the appointment of Professor Sir Mike Richards as the new Chief Inspector of Hospitals, and to highlight and inform governors of the ways in which they can share information and raise issues with the Care Quality Commission, and contribute to the new NHS inspections.</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>

		The Care Quality Commission will be piloting ways for governors to contribute directly to the new hospital inspections, as a further route to raising issues.	
79	There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for Foundation Trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.	<p>Accepted in principle.</p> <p>We agree that the public have the right to expect that people in leading positions in NHS organisations are fit and proper persons; and that where it is demonstrated that a person is not fit and proper, they should not be able to occupy such a position. Monitor's licence conditions for providers of NHS services already prevents licensees from allowing unfit persons to become or continue as governors or directors (or those performing similar or equivalent functions. They are also required to ensure that their contracts of service with its Directors contain a provision permitting summary termination in the vent of a Director being or becoming an unfit person. The Licensee is also required to ensure that it enforces that provision promptly upon discovering any Director to be an unfit person.</p> <p>The Government issued in July 2013 a consultation on <i>Strengthening corporate accountability in health and social care</i>. This proposes a new requirement that all Board Directors (or equivalents) of providers registered with the Care Quality Commission must meet a new fitness test. We are proposing that this test includes checks about whether the person is of good character including past employment history, if the individual has the qualifications, skills and experience necessary for the work or office, as well as the more traditional consideration of criminal and financial matters.</p> <p>The Government proposes that the fit and proper persons test will now be used as a mechanism for introducing a scheme for barring Directors who are unfit from individual posts by Care Quality Commission at the point of registration. Where a Director is considered by Care Quality Commission to be unfit it could either refuse registration, in the case of a new provider, or require the removal of the Director on inspection, or following notification of a new appointment. Further details will be set out in the response to the consultation on corporate accountability which will be published shortly. We plan to publish the draft regulations for consultation at the same time.</p> <p>The standards produced by the Professional Standards Authority (<i>Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England</i>) provide the basis for assessing the fitness of senior board-level leaders and managers.</p>	The Department of Health has consulted on a new registration requirement that all directors of providers registered with the Care Quality Commission must meet a fit and proper person test. The Care Quality Commission will be able to insist on the removal of directors that fail this test. The consultation included how the revised fit and proper person requirement will work, and questions about the impact of the new regulations. The <u>consultation</u> ran from 27 March to 25 April 2014. The Fit and Proper Persons Test Regulations have been passed by Parliament and are in place in November 2014 for NHS organisations and from April 2015 for other organisations.
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.	<p>Accepted in principle.</p> <p>We agree that the public have the right to expect that people in leading positions in NHS organisations are fit and proper persons; and that where it is demonstrated that a person is not fit and proper, they should not be able to occupy such a position. Monitor and the Care Quality Commission are committed to ensuring that, taken together, their processes for registration and licensing reflect these principles. Monitor's licence conditions already require providers to ensure that no person who is an unfit person may become or continue as a Director and that they ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person.</p> <p>In order to strengthen this, the Government issued in July 2013 a consultation on <i>Strengthening corporate accountability in health and social care</i>. This proposes a new requirement that all Board Directors (or equivalents) of providers registered with the Care Quality Commission must meet a new fitness test. We are proposing that this test includes checks about whether the person is of good character including past employment history, if the individual has the qualifications, skills and</p>	The Department of Health has consulted on a new registration requirement that all directors of providers registered with the Care Quality Commission must meet a fit and proper person test. The Care Quality Commission will be able to insist on the removal of directors that fail this test. The consultation included how the revised fit and proper person requirement will work, and questions about the impact of the new regulations. The <u>consultation</u> ran from 27 March to 25 April 2014. The Fit and Proper Persons Test Regulations have been passed by Parliament and are in place in November 2014 for NHS organisations and from April 2015 for other organisations.

		<p>experience necessary for the work or office, as well as the more traditional consideration of criminal and financial matters.</p> <p>The Government proposes that the fit and proper persons test will now be used as a mechanism for introducing a scheme for barring Directors who are unfit from individual posts by Care Quality Commission at the point of registration. Where a Director is considered by Care Quality Commission to be unfit it could either refuse registration, in the case of a new provider, or require the removal of the Director on inspection, or following notification of a new appointment. The Government believes that this will be a robust method of ensuring that Directors whose conduct or competence makes them unsuitable for these roles are prevented from securing them. The scheme will be kept under review to ensure that it is effective, and we will legislate in the future if the barring mechanism is not having its desired impact. Further details will be set out in the response to the consultation on corporate accountability which will be published shortly. We plan to publish the draft regulations for consultation at the same time.</p> <p>In addition to regulatory mechanisms, we also believe it is important for organisations appointing and employing senior leaders to use the means already available to them (most notably recruitment, appraisal, exit procedures and provision of references) to ensure and strengthen the quality of the senior leaders in their organisations and the wider system, and to identify and deal with issues of performance and behaviour. This will on occasion (but not always) include action to remove someone from a senior role. The Government, the Care Quality Commission, the NHS Trust Development Authority and Monitor will continue to work with NHS Employers and other organisations with a responsibility for and an interest in these issues to ensure a focus on improving the way that existing mechanisms operate. We believe that the focus for this issue should be the internal processes described above, and the Care Quality Commission's registration requirements rather than the constitution of the Foundation Trust.</p>	
81	<p>Consideration should be given to including the criteria for fitness a minimum level of experience and/or training, while giving appropriate latitude for recognition of equivalence.</p>	<p>Accepted.</p> <p>We agree that people in leading positions in NHS organisations should have the appropriate experience and training to take up those positions and that this should be one of the criteria for any assessment of whether someone is a fit and proper person. It is vital that they are assessed as a key element of the recruitment process and of ongoing appraisal. As set out in <i>The Healthy NHS Board 2013</i>, as well as experience and technical skill, values and behaviour are also critical to getting the right leaders in place. We also endorse the document's advice that regular skills audits of current board members should be carried out.</p> <p>Monitor's Risk Assessment Framework sets out how it oversees NHS Foundation Trusts compliance with the provider licence. Where a breach has occurred in respect of governance, one of the areas Monitor may investigate is the Foundation Trust's management and organisational capability in making an assessment about return to compliance. Monitor's Code of Governance for Foundation Trusts sets a clear expectation that there should be a formal, rigorous and transparent procedure for the appointment of directors and that care should be taken to ensure that new appointees have relevant skills and experience.</p> <p>Monitor is working with the Foundation Trust Network to offer a 2-day induction programme for new non-executive directors of NHS Foundation Trusts. The first of these programmes was run in September 2013. Monitor will be working together with the NHS Leadership Academy, NHS Trust Development Authority and Foundation Trust Network to increase external support for chief executives of NHS Trusts and Foundation Trusts. Monitor will also consider how best to support medical directors in the coming year.</p>	<p>Monitor has run a series of events with Chief Executive Officers to help identify their support needs and the follow-on action is now under consideration. The development of an induction event for Executive Directors including Medical and Nursing Directors is in hand. The need for further support will be reviewed in light of this work.</p>

82	<p>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.</p>	<p>Accepted.</p> <p>Under the revised registration requirements, in cases where a Director was deemed by the Care Quality Commission to be unfit, the Care Quality Commission will be able to insist on their removal by placing a condition on the provider's registration. If the provider failed to remove the director that would be an offence for breach of the condition, and the provider would be liable to prosecution.</p> <p>The Government proposes that the fit and proper persons test will now be used as a mechanism for introducing a scheme for barring Directors who are unfit from individual posts by the Care Quality Commission at the point of registration. Where a Director is considered by the Care Quality Commission to be unfit it could either refuse registration, in the case of a new provider, or require the removal of the Director on inspection, or following notification of a new appointment. Further details will be set out in the response to the consultation on corporate accountability which will be published shortly. The Government plans to publish the draft regulations for consultation at the same time.</p>	<p>The Department of Health has consulted on a new registration requirement that all directors of providers registered with the Care Quality Commission must meet a fit and proper person test. The Care Quality Commission will be able to insist on the removal of directors that fail this test. The consultation included how the revised fit and proper person requirement will work, and questions about the impact of the new regulations. The <u>consultation</u> ran from 27 March to 25 April 2014. The Fit and Proper Persons Test Regulations have been passed by Parliament and are in place in November 2014 for NHS organisations and from April 2015 for other organisations.</p>
83	<p>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.</p>	<p>Accepted.</p> <p>Monitor and the Care Quality Commission are committed to ensuring that, taken together, their processes for registration and licensing work effectively to ensure that people in leading positions are fit and proper persons. The Care Quality Commission will set out in guidance how it will apply the fit and proper persons test as part of its regulatory regime and will ensure that as far as possible its approach in relation to registration is aligned with Monitor's assessment of fitness as part of its licensing process (which applies to a narrower range of organisations than registration). Monitor has also published guidance on how it will exercise its enforcement powers which are used where there is a breach of licence conditions. This includes procedures for imposing additional licence conditions on NHS Foundation Trusts and removing, suspending or disqualifying directors or governors of NHS Foundation Trusts.</p>	<p>The fit and proper person requirement was put in place in November 2014 for directors of NHS Trusts, and in April 2015 for all providers of health and adult social care registered with the Care Quality Commission.</p> <p>The fit and proper person requirement provides an important mechanism to hold to account individual Directors that have been responsible for the provision of unacceptable standards of care and will assess whether directors:</p> <ul style="list-style-type: none"> • are of good character. • have the necessary qualifications, skills and experience. • are able to perform the work that they are employed for. • can supply information, such as certain checks and a full employment history.
84	<p>Where the contract of employment or appointment of an executive or non-executive is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit 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.</p>	<p>Accepted in principle.</p> <p>In cases where there are reasonable grounds that a person is not fit to hold such a post, we would expect this view to be reflected in the references provided by the employer to a prospective new employer. Prospective employers have a responsibility to seek references from previous employers. NHS Employers are working on how to support organisations so that all information relating to recruitment into Board positions is presented, known and used by employers. Rather than use a regulatory intermediary as a register of concerns about a person's fitness of the kind identified by this recommendation, we therefore believe it would be better to make references and recruitment processes more effective.</p> <p>We agree that the public has the right to expect that people in leading positions in NHS organisations are fit and proper persons; and that where it is demonstrated that a person is not fit and proper, they should not be able to occupy such a position. Monitor's licence conditions for providers of NHS services already prevents licensees from allowing unfit persons to become or continue as governors or directors (or those performing equivalent functions). They are also required to ensure that their contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee is also required to ensure that it enforces that provision promptly upon discovering any Director to be an unfit person.</p> <p>In order to strengthen this, the Government issued in July 2013 a consultation on <i>Strengthening corporate accountability in health and social care</i>. This proposes a</p>	<p>The Department of Health has consulted on a new registration requirement that all directors of providers registered with the Care Quality Commission must meet a fit and proper person test. The Care Quality Commission will be able to insist on the removal of directors that fail this test. The consultation included how the revised fit and proper person requirement will work, and questions about the impact of the new regulations. The <u>consultation</u> ran from 27 March to 25 April 2014. The Fit and Proper Persons Test Regulations have been passed by Parliament and are in place in November 2014 for NHS organisations and from April 2015 for other organisations.</p>

		<p>new requirement that all Board Directors (or equivalents) of providers registered with Care Quality Commission must meet a new fitness test. We are proposing that this test includes checks about whether the person is of good character including past employment history, if the individual has the qualifications, skills and experience necessary for the work or office, as well as the more traditional consideration of criminal and financial matters.</p> <p>The Government proposes that the fit and proper persons test will now be used as a mechanism for introducing a scheme for barring Directors who are unfit from individual posts by Care Quality Commission at the point of registration. Where a Director is considered by Care Quality Commission to be unfit it could either refuse registration, in the case of a new provider, or require the removal of the Director on inspection, or following notification of a new appointment. Further details will be set out in the response to the consultation on corporate accountability which will be published shortly. We plan to publish the draft regulations for consultation at the same time.</p>	
85	<p>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.</p>	<p>Accepted.</p> <p>In cases where a Director was deemed by the Care Quality Commission to be unfit, the Care Quality Commission would be able to insist on their removal by placing a condition on the provider's registration. If the provider then failed to remove the director that breach of the registration condition would be an offence for which the provider would be liable to prosecution.</p> <p>The Care Quality Commission will publish guidance setting out how the process will work, and how it will co-operate with Monitor and the NHS Trust Development Authority.</p> <p>Under the single failure regime, Monitor and the NHS Trust Development Authority would be able to use their existing powers to enforce fit and proper persons requirements (such as the removal of directors) on licence holders and NHS Trusts.</p>	<p>The Care Quality Commission is taking forward the development of a 'fit and proper persons' test for board-level leaders in the organisations registered with it, whether in the public, private or voluntary sectors. The fit and proper person test includes 'service misconduct' as a ground of unfitness.</p> <p>In cases where a Director was deemed by the Care Quality Commission to be unfit, the Care Quality Commission would be able to place a condition on the provider's registration. If the provider failed to demonstrate the director's fitness, the resultant breach of the registration condition would create an offence for which the provider would be liable to prosecution. The Care Quality Commission published guidance on the duty of candour and fit and proper person requirement for NHS bodies in November 2014.</p>
86	<p>A requirement should be imposed on Foundation Trusts to have in place an adequate programme for the training and continued development of directors.</p>	<p>Accepted.</p> <p>Monitor's licence conditions require providers to ensure that no person who is an unfit person may become or continue as a Director and that they ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee is also required to ensure that it enforces that provision promptly upon discovering any Director to be an unfit person.</p> <p>We agree that it is important for directors of all NHS organisations (including Foundation Trusts) to be provided with the development they need to operate effectively and responsibly. The recently published <i>The Healthy NHS Board 2013</i> document sets out a number of measures for the development of individual directors and boards as a whole, including 360 degree feedback, structured induction, peer learning, whole board performance assessment and individual appraisal. Monitor's Code of Governance for Foundation Trusts sets out an expectation that Directors should also have access, at the NHS foundation trust's expense, to training courses and/or materials that are consistent with their individual and collective development programme. Monitor's Quality Governance framework guidance also challenges boards to ensure they have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda. It also suggests boards conduct regular self-assessments to test its skills and capabilities and attend training sessions covering the core elements of quality governance and continuous improvement. Monitor already has in place programmes provided jointly</p>	<p>Three induction programmes have now been run for Foundation Trust Non-Executive Directors. The first joint Monitor/NHS Trust Development Authority conference for Chief Executive Officers and Chairs was held in October 2014 and is covered strategic planning and transaction guidance.</p>

		<p>with others to support chairs, non- executive directors and finance directors. Monitor additionally provides a one-day induction programme for new chairs and chief executives of NHS Foundation Trusts and is working with the Foundation Trust Network to offer a 2-day induction programme for new non-executive directors of NHS Foundation Trusts. The first of these programmes was run in September 2013 and the next cohort will take place in January 2014. Monitor will be working together with the NHS Leadership Academy, NHS Trust Development Authority and the Foundation Trust Network to increase external support for chief executives of NHS Trusts and Foundation Trusts and will also consider how best to support medical directors in the coming year. The Foundation Trust Network also offers development programmes for executive directors and company secretaries</p>	
87	<p>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.</p>	<p>Accepted in principle.</p> <p>The Care Quality Commission is the right organisation to focus on healthcare, investigate and act where patients have been seriously harmed because of unsafe or poor care. Investigation of such incidents can give early warning of more widespread management failure.</p> <p>The Government recognises that, although the Care Quality Commission is able to prosecute providers, directors and unincorporated associations under the Health and Social Care Act 2008, in practice there have been few prosecutions. This suggests that the Care Quality Commission's approach to enforcement needs to be strengthened. The Department of Health is developing revised requirements for registration with the Care Quality Commission to include fundamental standards that will enable prosecutions of providers to occur where patients have been harmed because of unsafe or poor care, without the need for an advance warning notice. This will ensure that the current regulatory gap identified in the Inquiry report is willed. <u><i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i></u> set out plans to introduce fundamental standards which will enable the Care Quality Commission to take more effective action, including prosecution, where there are clear failures to meet basic standards of care. On 17 October 2013, the Care Quality Commission published the responses to the consultation in <u><i>A new start: Responses to our consultation on changes to the way Care Quality Commission regulates, inspects and monitors care services</i></u> ,which showed that there is broad agreement with the new approach.</p> <p>The Department is also working with the Care Quality Commission and the Health and Safety Executive to ensure that the Health and Safety at Work Act 1974 and its relevant statutory provisions will continue to be used by the Health and Safety Executive where it provides for the most specific breaches. Given the Health and Safety Executive's more limited role for patient safety, the Care Quality Commission and the Health and Safety Executive will together develop and agree criteria and handling arrangements for the matters that the Health and Safety Executive will investigate.</p> <p>The Care Quality Commission and the Health and Safety Executive have published a Liaison Agreement, which describes how the two organisations currently work together. This will need to change to reflect the revised registration requirements, the Care Quality Commission's role, the criteria for matters which the Health and Safety Executive will investigate, and the mechanism for referral. The Care Quality Commission and the Health and Safety Executive will ensure that this is done in line with the implementation of the revised registration requirements.</p> <p>The Health and Safety Executive will support the Care Quality Commission in developing its role in investigating and prosecuting in cases of unacceptable care. The Department of Health will work with the Department of Work and Pensions and the Health and Safety Executive to ensure that Health and Safety Executive has the necessary capacity to support the Care Quality Commission.</p>	<p>Regulations will introduce new fundamental standards of care as requirements for registration with the Care Quality Commission. These will allow the Care Quality Commission to take robust action against providers that do not deliver an acceptable standard of care, including prosecution. The Care Quality Commission produces ratings of the quality of care ranging from outstanding to inadequate to provide service users with a fuller picture of the quality of care available. Regulations have been introduced for ratings from October 2014 and fundamental standards for health and adult social care provision in April 2015.</p>

88	<p>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.</p>	<p>Accepted in principle.</p> <p>Access to accurate and up to date information and intelligence is essential to the effective regulation of health and adult social care providers by the Care Quality Commission. In practice, few patient incidents fall under the category of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and the Care Quality Commission would in any case be informed of these incidents through the statutory notifications that registered providers are required to make them. In addition, there is an information sharing agreement in place between the Health and Safety Executive and the Care Quality Commission. Currently, in addition to the information shared via the Liaison Agreement, the Health and Safety Executive shares quarterly investigated RIDDOR accidents, complaints, and enforcement and prosecution notices data. This information will be shared on a more frequent basis under new working arrangements and will be reflected in the liaison agreement between the Care Quality Commission and the Health and Safety Executive.</p>	<p>The Health and Safety Executive, the Department of Health and the Care Quality Care are taking forward the recommendations of the Francis Inquiry and the Health and Safety Executive's Triennial Review with regard to the relationship between the Health and Safety Executive and the Care Quality Commission. The Care Quality Commission have consulted on a revised liaison agreement setting out their working arrangements including their criteria for referrals and prosecutions and better co-operation in the underpinning information-sharing arrangements. The final liaison agreement will be published in April 2015.</p> <p>Currently, the Health and Safety Executive shares quarterly investigated Reporting of Injuries, Diseases and Dangerous Occurrences Regulations accidents, complaints, and enforcement and prosecution notices data. This is part of the joint work by the Health and Safety Executive and the Care Quality Commission that is set out in a liaison agreement.</p> <p>The agreement will make clear that when fundamental standards are in place, the Care Quality Commission will have the lead role in considering whether to take enforcement action on safety incidents which affect people using services registered with it. The Health and Safety Executive or local authorities will have the lead in considering whether to take enforcement action on safety incidents affecting people using other health and care services, and for safety incidents affecting staff and the public in all services. The new liaison agreement will also set principles for case-by-case decisions on which regulator will take the lead in complex situations.</p> <p>This greater simplicity and clarity about when each regulator will take the lead, is expected to result in an increase in enforcement activity by Care Quality Commission. The Health and Safety Executive is providing Care Quality Commission with support and practical assistance, to help it build up the necessary capability to deliver this.</p>
89	<p>Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.</p>	<p>Accepted in principle.</p> <p>The Care Quality Commission is the regulator of the safety and quality of health and adult social care providers in England. Providers registered with the Care Quality Commission are required to notify it of serious untoward incidents involving death or serious injury either directly or through the National Reporting and Learning System in the case of NHS organisations. The Care Quality Commission uses the intelligence that it receives from these notifications as part of its risk assessment. An initial assessment of serious untoward incidents should be carried out by the Care Quality Commission as the specialist inspector of the health and adult social care providers, with the ability to draw on the Health and Safety Executive's expertise in investigations and prosecutions. This will be set out in the revised liaison agreement between the Care Quality Commission and the Health and Safety Executive.</p>	<p>The Health and Safety Executive shares quarterly investigated Reporting of Injuries, Diseases and Dangerous Occurrences Regulations accidents, complaints, and enforcement and prosecution notices data with Care Quality Commission. This is part of the joint work by Health and Safety Executive and Care Quality Commission that is set out in a liaison agreement. The Care Quality Commission have consulted on a revised liaison agreement setting out their working arrangements including their criteria for referrals and prosecutions and better co-operation in the underpinning information-sharing arrangements. The final liaison agreement will be published in April 2015.</p> <p>This agreement will make clear that when fundamental standards are in place, the Care Quality Commission will have the lead role in considering whether to take enforcement action on safety incidents which affect people using services registered with it. The Health and Safety Executive or local authorities will have the lead in considering whether to take enforcement action on safety incidents affecting people using other health and care services, and for safety incidents affecting staff and the public in all services. The new liaison agreement will also set principles for case-by-case decisions on which regulator will take the lead.</p>
90	<p>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</p>	<p>Accepted.</p> <p>The Health and Safety Executive has always sought expert advice. Such advice might come from its own specialist inspectors or subject matter experts, from staff within the Health and Safety Laboratory, from other regulators such as the Medicines and Healthcare products Regulatory Agency, from the Department of Health, from external associations such as the National Back Exchange, from independent medical</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>

	expert advice, as is done in the field of healthcare litigation and fitness to practise proceedings.	<p>practitioners who are experts in their field or others.</p> <p>The Care Quality Commission will also seek appropriate specialist advice in investigating potential breaches of the new fundamental standards.</p>	
91	The Department of Health and NHS Commissioning Board should consider what steps are necessary to require all NHS providers, whether or not they remain members or 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.	<p>Accepted in principle.</p> <p>We agree that the effectiveness of any national scheme of this kind to promote the improvement of risk management and any associated benefits for patient safety will be dependent on it continuing to have near universal coverage of providers. It is also accepted that the NHS Litigation Authority's risk management standards and assessments have assisted in improving processes for risk management in the NHS. However, the existence of a risk management system, even one complying with the NHS Litigation Authority's standards does not of itself mean that a trust is safe. There are many other factors that are relevant which should be considered when assessing whether practices are safe for staff and patients. The Government is clear that there should be fundamental standards that represent the basic requirements and that should be the core of all services. The new fundamental standards will sit within the legal requirements that providers of health and adult social care must meet to be registered with Care Quality Commission. Together with a new ratings systems, developed and published by the Care Quality Commission, providers will be assessed on how well they meet the standards for safe and high quality care.</p> <p>All NHS Trusts and Foundation Trusts are currently members of the NHS Litigation Authority's clinical negligence scheme. In addition, the number of independent providers funded to provide NHS healthcare joining the scheme, is increasing. The scheme is voluntary and there is no requirement for trusts that opt out to meet the NHS Litigation Authority's standards.</p> <p>As well as the Inquiry, recent reviews led by Sir Bruce Keogh and Professor Dr Don Berwick, when considered with the views of the NHS Litigation Authority's members, indicate that the time is right to move away from assessments against a set of risk management standards to a new outcome focused approach. The new approach to safety and learning will support members to reduce claims by focussing on areas which cause significant harm and in working towards improving clinical outcomes. These changes will also seek to reduce bureaucracy and the burden on front line staff, and avoid duplication with other agencies.</p> <p>This means that the NHS Litigation Authority risk management standards the Inquiry refers to will be discontinued and the last assessment will be carried out on March 2014. Therefore, the Department considers it would not be appropriate to require any NHS provider leaving the scheme to have and to comply with the outgoing standards.</p>	The NHS Litigation Authority ceased their assessments of members' compliance against their risk management standards from April 2014, reducing bureaucracy and the burden on front line staff and avoiding duplication with other agencies. Together with a new ratings system, developed and published by the Care Quality Commission, providers are now assessed by the Care Quality Commission on how well they meet the standards for safe and high quality care. The Care Quality Commission standards and inspection regimes apply across all registered providers of health and adult social care, and not only those organisations that are members of the NHS Litigation Authority's clinical negligence indemnity scheme.
92	The financial incentives at levels below level 3 should be adjusted to maximise the motivation to reach level 3.	<p>Accepted.</p> <p>From 1 April 2013, the NHS Litigation Authority introduced a revised pricing methodology for the Clinical Negligence Scheme for Trusts.</p> <p>The new approach means that organisations with a good claims record will see the benefit of this in their Clinical Negligence Scheme for Trusts pricing whereas those organisations with a less favourable claims history will contribute more to the risk pool. These changes were discussed extensively with members of the scheme. The Department of Health and other relevant parties across the system agreed this represents a more equitable way of distributing the costs of the scheme.</p> <p>The NHS Litigation Authority is also already bringing the focus of NHS organisations onto their claims activity which it is hoped will in turn assist in reducing the costs associated with Clinical Negligence Scheme for Trusts and ultimately reduce the level of harm to patients.</p>	In 2013 the NHS Litigation Authority informed the NHS that it would be moving away from the system of risk management discounts on members' contributions whilst aiming to avoid large swings in price for members who currently receive discounts. The revised pricing methodology, which has been in place since April 2013, financially rewards organisations with fewer, less costly claims and financially incentivises organisations to focus on their claims with a view to reducing them, thereby reducing harm and improving patient and staff safety. In addition, the NHS Litigation Authority is supporting Sign up to Safety, the campaign launched by the Secretary of State for Health that aims to listen to patients and staff, learn from when things go wrong and act to make care safer. The NHS Litigation Authority will review members' safety plans and where they aim to reduce claims and are robust, the NHS Litigation Authority will make a payment to support implementation of the safety improvement plan.

93	<p>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.</p>	<p>Accepted in principle.</p> <p>As in the response to recommendation 91, the NHS Litigation Authority will move away from assessments against a set of risk management standards to a new outcome focused approach. The new approach which will support members to reduce claims by focussing on areas which cause significant harm and in working towards improving clinical outcomes. These changes will also seek to reduce bureaucracy and the burden on front line staff, and avoid duplication with other agencies.</p> <p>The NHS Litigation Authority is not in a position to introduce requirements with regard to the observance of guidance in relation to staffing levels, or to require the assessment of appropriate skill mix, staffing level and staff patient ratios. It is for trusts (and where appropriate, regulators) to have regard to evidence based guidance and benchmarks and to undertake effective risk assessments when changes to numbers or skills of staff are under consideration.</p> <p>However, the NHS Litigation Authority's revised pricing methodology for setting member contributions for their indemnity cover takes account of staffing and activity levels. This mean that if all other factors are equal, organisations which have more staff to undertake activities with the same level of risk will pay less for their indemnity cover. It also ensures that organisations with fewer claims pay less for the indemnity cover, therefore rewarding safer organisations.</p>	<p>From April 2013 the pricing approach for the Clinical Negligence Schemes for Trusts was changed to take greater account of claims paid and those in the process of being resolved. It also takes into account staffing and activity levels across higher risk service areas. The pricing approach rewards organisations with fewer less costly claims and thereby financially incentivises organisations to reduce their claims and thereby reduce harm and improve patient and staff safety.</p>
94	<p>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 the development of a relatively simple database containing the same information.</p>	<p>Accepted.</p> <p>The NHS Litigation Authority has launched a new extranet which provides members with detailed information about their claims so they can easily identify areas where they need to focus on reducing claims. The information is real time and shows total volumes and values but also broken down by speciality. Members can use the information to benchmark themselves against similar organisations.</p> <p>The extranet also provides materials to support learning.</p>	<p>The NHS Litigation Authority launched its extranet service for members during 2013-14. They share more data with members to help them reduce claims and improve patient and staff safety. The extranet now provides members with real-time access to their claims data together with learning resources. It enables them to log new claims, track the progress of ongoing claims, and assess and manage their risk. It also provides learning materials such as case studies to enable shared learning across the NHS. The data can help the NHS to prevent harm to patients and staff which might otherwise lead to future claims against the NHS.</p>
95	<p>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.</p>	<p>Accepted.</p> <p>In response to the Caldicott Review, <i>Information: To Share or Not to Share (2013)</i>, the Department of Health stated that health and care professionals must make decisions about how information is shared and used in the best interests of people and patients using the five rules of confidentiality set out in new Health and Social Care Information Centre's guidance, <i>Guide to Confidentiality in Health and Social Care (2013)</i>.</p> <p>The NHS Litigation Authority also supports the view that the patient safety should prevail over litigation interests. It actively supports explanations and apologies and will never refuse to indemnify a member because they have apologised. It shares information which supports learning from claims with the NHS and makes such information available to members and where appropriate, other stakeholders. The NHS Litigation Authority is sharing relevant claims information as part of the Care Quality Commission's inspection regime. The NHS Litigation Authority is also putting in place an information sharing agreement with regulators to enable us to share relevant information.</p>	<p>The NHS Litigation Authority shares relevant claims information (with due regard to data protection and patient confidentiality) as part of the Care Quality Commission's inspections regime and where appropriate with other regulators. The NHS Litigation Authority has published a set of data sharing principles which sets out the basis upon which it will share data whilst appropriately maintaining confidentiality. The overriding principle is to share information to support patient safety.</p>
96	<p>The NHS Litigation Authority should make more prominent in its publicity an</p>	<p>Accepted.</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>

	<p>explanation comprehensible to the general public of the limitations of its standards assessments and of the reliance which can be placed on them.</p>	<p>The NHS Litigation Authority has included a comprehensible explanation of the limitations of the standards and assessments process on its website. Following the publication of the NHS Litigation Authority's Industry Review in January 2012, the NHS Litigation Authority has reviewed the standards and assessment process and advised members that it is moving away from assessment against standards to an outcome focus approach. This will support the NHS to learn from claims by sharing information and learning and through price incentivisation.</p>	
97	<p>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.</p>	<p>Accepted in part.</p> <p>The functions of the National Patient Safety Agency were moved to NHS England in order to ensure that improving safety is core business for the NHS. The Department of Health and NHS England agree this vital function should continue to have its resources protected. The Mandate for NHS England includes the objective to continue to reduce avoidable harm and make measurable progress by 2015 to embed a culture of patient safety in the NHS including through improved reporting of incidents. NHS England will be held accountable for progress against the objectives and will use its position as the leadership body for the NHS to support quality improvement throughout the healthcare system, which by definition includes safety improvement.</p> <p>Patient safety is a critical component of what an effective regulator seeks to secure, maintain and improve and is rightly at the heart of the Care Quality Commission's new inspection regime. The Chief Inspector of Hospitals' assessment will include an inspection for patient safety which will inform the ratings of all NHS providers. In addition, the Care Quality Commission and NHS England will work closely together to share information, including reported incidents from the National Reporting and Learning System, to support Care Quality Commission's surveillance and inspection.</p> <p>The Government has considered the case for the transfer of the functions of the National Patient Safety Agency to a system regulator. These functions were primarily focused on learning, improvement and innovation rather than regulation and assurance. The core functions were to collect patient safety incident reports from all healthcare organisations, so that those reports could be analysed by safety experts in order to learn from what had gone wrong and then to use that knowledge to encourage patient safety improvement across the system. No system is ever 100% safe and patient safety demands an active commitment to continually reducing harm. Professor Don Berwick's report, <i>Improving the Safety of Patients in England</i>, emphasises that regulation is a crucial component of patient safety, but is not sufficient alone to secure patient safety. Ensuring the continual reduction of harm to patients requires the underlying culture of the NHS to be devoted to learning, improvement and innovation, and delivering that is a role that goes much wider than the system regulator's remit. The Government believes this role rightly sit within NHS England.</p> <p>In order to realise the Berwick report's vision of the NHS as an organisation devoted to continual learning and improvement, NHS England and NHS Improvement Quality are leading to establish a nationwide Patient Safety Collaborative Programme and will bring a significant level of resource and support to patient safety and improvement science over the next 5 years. Each collaborative will be locally-led and nationally supported. They will be designed to inspire and support a culture of continuous learning and improvement of patient safety in the NHS and be expected to deliver on a set of core patient safety priorities as well as their own priorities. As set out in the NHS Mandate refresh, NHS England and NHS Improvement Quality will seek to finalise the design of the programme, put in place the support and development capacity and recruit participating organisations by spring 2014. NHS England is also working with others on the best ways to develop much greater patient safety capability in the NHS through the education and training of the healthcare workforce in patient safety skills.</p>	<p>In the wake of the Public Inquiry - with the Care Quality Commission now making rapid progress to improve the rigour and effectiveness of its surveillance, inspection and ratings responsibilities for patient safety; NHS England now focusing primarily on the commissioning of safe services; the new development of the patient safety transparency website; and the launch of the new national Sign up to Safety Campaign – the Government agrees with Sir Robert that it makes sense to concentrate and consolidate national expertise and capability on safety within a single organisation that can provide strategic leadership across the whole healthcare system.</p> <p>The Department of Health will therefore consider with relevant organisations the options for transferring NHS England's responsibilities for to a single national body.</p>

98	<p>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.</p>	<p>Accepted in principle.</p> <p>Reporting of patient safety incidents involving severe harm and death is already mandatory nationally under the Care Quality Commission regulations and these incidents are actively reviewed by NHS England as well as being shared with the Care Quality Commission.</p> <p>The Government's current policy is not to introduce a mandatory reporting system at this stage however the Government does agree there should be a new duty on providers to be candid to patients (as set out in recommendation 174) and more should be done to promote the reporting of all patient safety incidents among healthcare professionals (as set out in recommendation 181).</p> <p>The National Reporting and Learning System already receives over 1.2 million incident reports a year and NHS England continues to encourage increased reporting from across the healthcare system. Indicator 5.1 of the NHS Outcomes Framework requires that the NHS continues to increase the numbers of incidents that are reported to the National Reporting and Learning System as this is a good indication of the development of a mature patient safety culture where organisations are open about incidents. NHS England will continue to drive the development of the safety culture within the NHS, not least by implementing relevant recommendations from the Berwick report. Organisations should routinely collect, analyse and respond to local measures that serve as indicators of the level of quality and safety of healthcare, including the voices of patients and staff, staffing levels, the reliability of critical processes and other quality metrics.</p> <p>As stated in recommendation 97, the Chief Inspector of Hospitals' assessment will include an inspection for patient safety which will inform the ratings of all NHS providers and the Care Quality Commission and NHS England will work closely together to share information, including reported incidents from the National Reporting and Learning System, to support Care Quality Commission's surveillance and inspection.</p>	<p>As set out in the updated response to Recommendation 12, patient safety incident reporting to the National Reporting and Learning System continues to increase year on year. Data published in April 2014 showed that in the six months from April 2013 to September 2013, 725,314 incidents in England were reported to the National Reporting and Learning System, 8.9% more than in the same period in the previous year.</p> <p>Following close liaison between the Care Quality Commission and NHS England, the Care Quality Commission's new Intelligent Monitoring system now assesses the patterns of incident reporting to the National Reporting and Learning System by flagging as at risk or at elevated risk all organisations demonstrating any of the following:</p> <ul style="list-style-type: none"> • potential under-reporting of patient safety incidents as suggested by organisations who are reporting significantly fewer patient safety incidents than other organisations • potential under-reporting of patient safety incidents causing death and severe harm as suggested by organisations who are reporting significantly fewer of these kinds of incidents than other organisations • potential under-reporting of patient safety incidents involving no harm as suggested by organisations who report a significantly higher proportion of incidents involving harm than other organisations • poor organisational commitment to monthly reporting of incidents to the National Reporting and Learning System, as demonstrated by reporting 3 months or less out of six; or • where a hospital has significantly lower scores than other organisations in relation to the percentage of staff who report their organisations' procedures and responses to incident reports are fair and effective via the NHS Staff Survey. <p>On 24 June 2014, NHS England published the results of a new indicator on the NHS Choices website, rating NHS hospitals for their incident reporting. A good reporting culture in an organisation means that the organisation reports patient safety incidents frequently, reports the more serious incidents that occur but also reports many incidents involving low and no harm to patients, because its staff understand that by reporting even these less serious incidents, the organisation can learn and improve. A good reporting culture is also indicated by the staff of a hospital saying they think the organisation has fair and effective procedures when incidents are reported. These aspects of incident reporting have been combined to give a composite rating for each acute hospital's reporting culture. The rating does not describe whether a hospital is safe, but does provide patients with authoritative and easy to access information on how well developed the organisation's patient safety incident reporting culture is and will encourage organisations to improve their reporting culture.</p> <p>Work to re-commission the National Reporting and Learning System is underway in NHS England with ongoing stakeholder and expert engagement being used to inform the design phase. The options development and appraisal will be progressed in Q3 and Q4 of 2014/15 with the revised design confirmed by the end of March 2015, subject to approvals. The procurement of the new system will then progress over the 2015/16 financial year.</p>
99	<p>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.</p>	<p>Accepted in principle.</p> <p>This recommendation refers to the reporting of patient safety incidents by individuals as opposed to via the 'standard' route of uploading incident reports from organisations' local risk management systems. It is predicated on the view that these reports may contain more information than those reported via an organisation's own reporting system (the 'corporate version') and are of use where individuals feel unable to report an incident to their own organisation.</p> <p>An online incident reporting e-form that can be used by individual staff, patients and the public to report patient safety incidents directly exists. While staff who use the online e-form form are encouraged to also report the incident to their</p>	<p>As set out in the updated response to Recommendation 12, patient safety incident reporting to the National Reporting and Learning System continues to increase year on year.</p> <p>On 24 June 2014, NHS England published the results of a new indicator on the NHS Choices website, rating NHS hospitals for their incident reporting. The rating does not describe whether a hospital is safe, but does provide patients with authoritative and easy to access information on how well developed the organisation's patient safety incident reporting culture is and will encourage organisations to improve their reporting culture.</p> <p>Work to re-commission the National Reporting and Learning System is underway</p>

		<p>employer's local systems, there is no automatic link back to local systems. Therefore there is a risk that by encouraging wider use of reporting routes that avoid local organisations' own reporting systems, important information about the incident may not reach the organisation concerned. This would severely compromise local learning and improvement. In addition, creating an automatic link may well discourage people from using the e-form if they are concerned about the response of the organisation in question. Taking into account these considerations, NHS England will consider how to make the online e-form more widely available and explore the feasibility of online reports being fed back to trusts at the same time as they are reported to the National Reporting and Learning System. NHS England is reviewing the National Reporting and Learning System in order to redesign and re-commission the system to ensure it is more responsive, easier and simpler to use and makes incident reporting and feedback a more worthwhile activity for users. In particular, NHS England is looking to make sure the reporting portal is more widely known and advertised.</p> <p>More importantly, NHS England's programme of work will further encourage a culture in the NHS where staff feel able to report any incident to their own organisation in as full and informative a way as necessary. This together with work being taken forward by the professional regulators in response to recommendation 181, should create a more open and transparent culture and promote a climate of learning to drive improvements in patient safety.</p>	<p>in NHS England with ongoing stakeholder and expert engagement being used to inform the design phase. Consideration is actively being given to the importance of making incident reporting as easy and widely accessible as possible through direct reports by individuals, including staff and patients. Further development of the e-form as well options to allow access via web and smart phone apps is being considered within the redesign. The options development and appraisal will be progressed in Q3 and Q4 of 2014/15 with the revised design confirmed by the end of March 2015, subject to approvals. The procurement of the new system will then progress over the 2015/16 financial year.</p>
100	<p>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.</p>	<p>Accepted in principle.</p> <p>All serious incidents involving severe harm and death reported by individuals to via the on-line e-form, or any route, are routinely shared with the Care Quality Commission on a weekly basis. The Care Quality Commission also receives all incident reports to the National Reporting and Learning System on a weekly basis, regardless of the seriousness of the incident or the source of the report. The Care Quality Commission also has direct access to the national Serious Incident reporting system, STEIS (the Strategic Executive Information System), which is used by commissioners and providers to report and manage serious incidents in NHS-funded care. It is therefore able to view all the information submitted to that system regarding Serious Incidents as well.</p> <p>The Government does not support the view at this stage that there should be a mandatory reporting system for all incidents however, as set out in recommendation 98, NHS England and the Care Quality Commission are committed to working together to develop a shared and agreed approach to measuring safety in the NHS, both for regulatory and improvement purposes. NHS England and the Care Quality Commission are working together to agree a set of patient safety measures, including all incidents reported. The Care Quality Commission will also be reviewing its approach to looking at serious untoward incidents as part of our pre- inspection activity.</p>	<p>As set out in the update to recommendation 98, NHS England and the Care Quality Commission have co-developed a new set of indicators that are used in the Care Quality Commission's Intelligent Monitoring system that flag as at risk or at elevated risk all organisations demonstrating any of the following:</p> <ul style="list-style-type: none"> • potential under-reporting of patient safety incidents as suggested by organisations who are reporting significantly fewer patient safety incidents than other organisations • potential under-reporting of patient safety incidents causing death and severe harm as suggested by organisations who are reporting significantly fewer of these kinds of incidents than other organisations • potential under-reporting of patient safety incidents involving no harm as suggested by organisations who report a significantly higher proportion of incidents involving harm than other organisations • poor organisational commitment to monthly reporting of incidents to the National Reporting and Learning System, as demonstrated by reporting 3 months or less out of six; or • where a hospital has significantly lower scores than other organisations in relation to the percentage of staff who report their organisations' procedures and responses to incident reports are fair and effective via the NHS Staff Survey.
101	<p>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.</p>	<p>Accepted.</p> <p>Patient Environment Action Team inspections have now been replaced by Patient-led Assessments of the Care Environment. These are annual inspections of all NHS hospitals (and some independent sector ones) that cover provisions for privacy and dignity, cleanliness, food, and general décor/maintenance of hospital buildings. They are carried out by teams that include at least 50% patients or members of the public, which increases the external scrutiny (the Patient Environment Action Team process was entirely self-assessment). The Department of Health has advised that Patient-led Assessments of the Care Environment assessments should also include an external validator.</p>	<p>As stated in our initial response, Patient-led Assessments of the Care Environment replaced Patient Environment Action Team inspections early in 2013. Fieldwork for the 2014 round of Patient-led Assessments of the Care Environment assessments was carried out between February and June 2014 and the <u>outcomes</u> were published by the Health and Social Care Information Centre in August 2014. The Health and Social Care Information Centre also provide additional support for independent reviews through making available a list of volunteer independent reviewers. The Care Quality Commission calculates an overall trust Patient-led Assessments of the Care Environment score that incorporates the scores for each of the four domains to assess the final risk for the Patient-led Assessments of the Care Environment indicator within Intelligent Monitoring since July 2014. The Care Quality Commission is still happy to</p>

		<p>External validation, in this context, means that an individual with experience of the patient assessment process attends the assessment at another organisation to observe the process and ensure that it is conducted in accordance with published advice, guidelines and recommendations. Such individuals do not normally take part in the assessment and would not count as a Patient Assessor for the purposes of ensuring a minimum of 50% of assessors were from outside the organisation being assessed. Patient-led Assessments of the Care Environment inspections are voluntary, but in the first year (2013) every single eligible NHS hospital and well over 200 independent sector hospitals took part. The results are used by the Care Quality Commission in their risk assessment of sites prior to inspection.</p> <p>Importantly, the principle of this recommendation will also be met through the new functions of the Chief Inspector of Hospitals and Care Quality Commission's inspection regime. The Chief Inspector of Hospitals is expected to provide an honest and independent assessment about how well or badly hospitals are serving patients and the public. Expert inspections are envisaged whereby inspectors will be specialists in the areas they review; and judgement will be based on first-hand expert experience combined with data and feedback from patients and staff. Building on the approach developed by Professor Sir Bruce Keogh's reviews of mortality in 14 NHS trusts, the Chief Inspector of Hospitals has started inspections involving teams made up of senior and junior doctors, nurses and allied health professionals; senior managers; and people with experience of using hospital services. Six thousand individuals put themselves forward to be part of these inspections, and the number continues to increase. This is encouraging progress towards ensuring that inspection teams with a range of specialist and lay perspectives will be sustainable.</p>	<p>provide a representative to support Patient-led Assessments of the Care Environment assessments should NHS England seek its input.</p>
102	<p>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.</p>	<p>Accepted.</p> <p>In its response to the Caldicott Review, Information: To Share or Not to Share (2013), the Department of Health stated that health and care professionals must make decisions about how information is shared and used in the best interests of people and patients using the five rules of confidentiality set out in new Health and Social Care Information Centre guidance, Guide to Confidentiality in Health and Social Care (2013). This guidance provides a balance between confidentiality and information sharing and states that, 'People using services deserve a lot more than just information security. Individuals need the teams of professionals who are responsible for their care to share information reliably and effectively. Confidential information about an individual must not leak outside of the care team, but it must be shared within it in order to provide a seamless, integrated service.'</p> <p>Greater sharing of National Reporting and Learning System information is a stated aim of NHS England, within the bounds of an information governance framework. NHS England publishes patient safety incident data from the National Reporting and Learning System including information on levels and severity of harm to patients. NHS England is exploring the extent to which information on Serious Incidents can be disclosed in more detail without breaching the Data Protection Act. As part of the review of the National Reporting and Learning System, NHS England is considering how greater access can be provided to others for the purposes of analysis of patient safety incident data. Fundamentally NHS England is of the view that improving patient safety is more important than preserving unnecessary confidentiality.</p> <p>The National Clinical Assessment Service, previously a division of the National Patient Safety Agency, was transferred to the NHS Litigation Authority in April 2013. The release of information relevant to this service is consistent with the NHS Litigation Authority's approach to making information and data available which is not subject to data protection legislation and regulation, and would not result in breach</p>	<p>On 24 June 2014, a new NHS Choices microsite was launched which for the first time brings together a range of meaningful patient safety data that can be used by patients and the public to understand more about the safety of services. The data includes information on incident reporting, infection control and cleanliness, staffing levels, patient safety alert compliance, risk assessment for blood clots, data on pressure ulcer and harmful fall prevalence from the NHS Safety Thermometer, the Care Quality Commission's assessment of compliance with their national standards, and data on the proportion of staff who would recommend the organisation if their family or friends needed treatment. These are now incorporated on My NHS, which alongside other data allows for greater scrutiny and comparison of the performance on similar organisations in terms of quality and safety.</p> <p>NHS England began the monthly publication of never event data from April 2014.</p> <p>NHS England makes data on patient safety incidents available to a wide range of patient safety researchers, academics and improvement specialists via the form of Data Sharing agreements. This data is used as the source material for published studies, supports innovation in safer care and tackles key themes and areas of risk identified by professionals outside of NHS England. The Care Quality Commission also has unfettered access to all patient safety incidents reported to the National Reporting and Learning System.</p>

		<p>confidentiality and/or rules of the court or litigation practice.</p> <p>The Care Quality Commission and NHS England will develop a dedicated hospital safety website for the public which will draw together up to date information on all the factors, for which robust data is available, that impact on the safety of care. This will include information on staffing, pressure ulcers, healthcare associated infections and other key indicators, where appropriate, at ward level. The website will aim to begin publication from June 2014. This will over time become a key source of public information, putting the truth about care at the fingertips of patients. NHS England will begin to publish never events data quarterly before the end 2013, and then monthly by April 2014 to help Trusts, patients and the public drive improvement of services. In addition, new Patient Safety Collaboratives will be created from April 2014, which will bring together expertise on learning from mistakes, encourage open reporting of safety incidents and near misses, and support NHS organisations to take a rigorous approach to transforming patient safety. Initial priorities will include tackling pressure ulcers, hospital associated infections, falls and medication errors. The National Director of Patient Safety, Dr Mike Durkin, will lead the work to develop the collaboratives.</p>	
103	The National Patient Safety Agency or its successor should regularly share information with Monitor.	<p>Accepted.</p> <p>NHS England is actively working directly with Monitor to ensure they have access to patient safety data they require and that they are able to use it appropriately. NHS England agrees that the Care Quality Commission will also play a key role in coordinating the patient safety information to be shared or highlighted with organisations such as Monitor. More widely, NHS England is working to collate and make available a patient safety measurement framework to provide more clarity on patient safety data available, and what it can be used for and not used. Ultimately NHS England, Monitor, the Care Quality Commission and the NHS Trust Development Authority will work to bring together a common dataset for quality which could be used in a consistent way by all commissioners and regulators.</p> <p>National Clinical Assessment Service previously a division of the National Patient Safety Agency was transferred to the NHS Litigation Authority in April 2014. The NHS Litigation Authority is also developing a data sharing process for sharing relevant information with Monitor, the Care Quality Commission and the NHS Trust development Authority to support patient and staff safety.</p>	NHS England and Monitor have established data sharing arrangements for the sharing of National Reporting Learning System data including the agreement to share the National Reporting and Learning System data monthly. This agreement has been in place since April 2014. In addition, the Care Quality Commission's Intelligent Monitoring system which NHS England has helped to develop now provides the authoritative view of patient safety and wider quality-related data in the NHS.
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.	<p>Accepted.</p> <p><u><i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i></u> set out the Care Quality Commission's intentions to gather information from a range of sources to inform its work. It noted that the Care Quality Commission's Chief Inspectors will use the expert judgements of their teams of inspectors, together with information and evidence held both by the Care Quality Commission and its partners in the system, to provide a single, authoritative assessment of the quality and safety of care services. <u><i>A New Start</i></u> made clear that the Care Quality Commission would be looking, among other things, at whether a service is safe (i.e. people are protected from physical, psychological or emotional harm) and set out proposals for safety indicators. The consultation closed on 12 August 2013, and responses were considered alongside the recommendations from the Berwick Review, <u><i>Improving the Safety of Patients in England</i></u>, which included recommended actions around better streamlining of data requests via the Care Quality Commission acting as the coordinating hub for intelligence about quality and safety of care. On 17 October 2013, the Care Quality Commission published the responses to its consultation in <u><i>A new start: Responses to our consultation on changes to the way Care Quality Commission regulates, inspects and monitors care services</i></u>, which showed that there is broad agreement with the new approach. NHS England and the Care Quality Commission are committed to working together</p>	NHS England and the Care Quality Commission have worked jointly to ensure a shared view of patient safety data (and what it means) is developed, and that this is reflected in the new Care Quality Commission's surveillance model for acute and specialist NHS trusts. The Care Quality Commission now has free and unfettered access to all incident reporting information collected by the National Reporting and Learning System and through the Strategic Executive Information System. The Care Quality Commission and NHS England's Patient Safety Domain regularly meet to share information, review and co-develop initiatives to improve patient safety. For example, NHS England and the Care Quality Commission have co-developed a new set of indicators that are used in the Care Quality Commission's Intelligent Monitoring system. In March and July 2014, the Care Quality Commission updated its <u><i>surveillance model for acute and specialist NHS trusts</i></u> .

		<p>to develop a shared and agreed approach to measuring safety in the NHS, both for regulatory and improvement purposes. They are working to develop a set of patient safety measures that are best suited for use the Care Quality Commission in their surveillance model and NHS England is providing patient safety expertise on how patient safety data might be used by the Care Quality Commissions for its surveillance and inspection processes. A joint statement between NHS England and the Care Quality Commission is being published setting out how the two organisations will align their work to support inspection and surveillance work for safety.</p> <p>The National Clinical Assessment Service, previously a division of the National Patient Safety Agency transferred to the NHS Litigation Authority in April 2013. The NHS Litigation Authority is also putting in place an information sharing agreement with regulators, which will include relevant information relating to the National Clinical Assessment Service.</p>	
105	<p>Consideration should be given to whether information from incident reports involving deaths in hospital could enhance consideration of the hospital standardised mortality ratio.</p>	<p>Accepted.</p> <p>As part of Professor Sir Bruce Keogh's <i>Review of the Quality and Safety of Care and Treatment Provided by 14 Hospital Trusts in England</i>, NHS England provided detailed reports from the National Reporting and Learning System for each of the 14 trusts that were looked at. That process was informative and resulted in key lines of inquiry for the inspection teams on the ground. It in effect acted as a pilot for a stronger method of utilising the National Reporting and Learning System data in Care Quality Commission inspections. It was also found that data from the National Reporting and Learning System correlated well with other datasets to indicate problems with safety. NHS England will work with the Care Quality Commission to build on the learning from Sir Bruce Keogh's Review to address this. NHS England is also leading work to develop proposals for ensuring every trust undertakes retrospective case note reviews of patient deaths according to a consistent methodology to further encourage learning from adverse events. This will help trusts address common issues associated with avoidable hospital mortality, such as management of deteriorating patients.</p>	<p>NHS England was already exploring the development of a standardised process for supporting the NHS to undertake retrospective case note review. Introducing a national standard approach for undertaking case note review would build on innovative work at the London School of Hygiene and Tropical Medicine and has the potential to enable NHS Trusts to develop a better understanding of actually avoidable deaths.</p> <ul style="list-style-type: none"> • Although case note reviews are a "gold standard approach" they can be time and resource intensive. • NHS England are moving ahead now to develop a national rate and produce an estimate number of avoidable deaths for each hospital. This will be done by someone independent of Trusts and the numbers will be made public. Trusts will be expected to report annually to the Secretary of State for Health on their actions to reduce avoidable deaths.
106	<p>HPA and its successor, should co-ordinate 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</p>	<p>Accepted.</p> <p>Public Health England, which since April 2013 has taken on the functions of the Health Protection Agency, is working together with the Health and Social Care Information Centre to coordinate the collection, analysis and publication of information in relation to Healthcare Associated Infections. This includes a number of on-going activities: exploration of linkage of Public Health England Healthcare Associated Infections patient-level surveillance data with Hospital Episode Statistics data for enhanced epidemiological analyses; exploration of linkage of Public Health England Healthcare Associated Infections surveillance data with the death registrations (for mortality trends) to improve understanding of causality; Public Health England facilitation of voluntary surveillance within the Infections in Critical Care Quality Improvement Programme to increase the knowledge and evidence base, leading to quality improvement; a review of priority categories for Surgical Site Infection surveillance to inform strategic development and support needs of local users; taking a key role in the finalisation, roll-out and on-going development of the new Data Capture System to incorporate and support the above- mentioned surveillances activities. Public Health England is also working with trusts and Clinical Commissioning Groups to facilitate the Post Infection Review process for MRSA.</p>	<p>Public Health England publishes as routine mandatory surveillance data on Meticillin-resistant <i>Staphylococcus aureus</i> (MRSA), Meticillin-sensitive <i>Staphylococcus aureus</i> (MSSA) and <i>Escherichia coli</i> (<i>E. coli</i>) bloodstream infections and <i>Clostridium difficile</i> infection (CDI) at the level of each NHS acute trust. Trusts report these data to a web-based data capture system. Public Health England is providing expertise to support the development of a new integrated and future-proofed data capture system for its mandatory healthcare associated infection surveillance programmes which can be used by all parts of the healthcare system.</p> <p>Public Health England also provides expertise to support NHS organisations reporting positive cases of Meticillin-resistant <i>Staphylococcus aureus</i> bloodstream infection in undertaking a Post Infection Review for each case. A Post Infection Review is undertaken to identify how a case occurred, actions which can prevent a reoccurrence and the organisation best placed to ensure improvements are made. Public Health England has successfully liaised with NHS England to refine the Post Infection Review process from April 2014 so that cases of Meticillin-resistant <i>Staphylococcus aureus</i> bloodstream infection can be more accurately assigned to either an acute trust, Clinical Commissioning Group or 'third party' acknowledging the complex nature of cases.</p> <p>In order to assess patient outcomes, Public Health England has successfully linked data both on bloodstream infections and surgical site infection (hip</p>

		<p>Additionally, Public Health England is providing advice and support to the Care Quality Commission in its regulatory work to develop its new surveillance model for the construction of quality indicators.</p>	<p>replacement and other types of surgery) to the Office for National Statistics death registration data. Before the end of March 2015, Public Health England will assume responsibility for producing mortality data for cases of Meticillin-resistant <i>Staphylococcus aureus</i> bloodstream infection and Clostridium difficile infection by linking Public Health England mandatory surveillance data with death registration data. This data will be published on an annual basis.</p>
107	<p>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.</p> <p>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.</p>	<p>Accepted.</p> <p>Public Health England is reviewing its governance framework which underpins its responsibilities (in partnership with local, regional and national partners) for sharing and escalating concerns. As part of this work and as new structures emerge, Public Health England is revisiting and updating its internal operational guidelines, which provide a standardised risk-based approach within the framework, for its regional centres. This work formalises the process whereby Public Health England internally escalates, and informs local and national commissioners and regulators about, any concerns they might have regarding the management of Healthcare Associated Infection-related risks linked with health and adult social care providers (e.g. during outbreaks and incidents of infectious diseases).</p> <p>A peer support toolkit, previously developed by the Health Protection Agency (whose functions were transferred into Public Health England from 1 April 2013), is also under review. The toolkit clarifies the process whereby expert and peer support might be offered to, or requested by, healthcare providers. It includes recommended timelines, and the format the advice might take, as deemed appropriate for the situation.</p> <p>Following discussions with the key parties outlined in this recommendation, joint draft proposals are being developed to share expertise across all the key stakeholders in relation to infection, including those that are healthcare associated. These stakeholders include the Care Quality Commission, Monitor, NHS England and the NHS Trust Development Authority. The draft proposals strengthen current practices on information sharing among these organisations and will also establish an agreed set of principles and information flows setting out the lines of communication for sharing information where there are concerns that may require further investigation. The overarching principles and lines of communication were established in July 2013.</p>	<p>Public Health England has been undertaking work to review and revise arrangements for the sharing of information and escalation of concerns relating to the management of healthcare associated infections by health and adult social care providers. This includes procedures for internal escalation within Public Health England and escalation to relevant external bodies, such as commissioners and regulators, both locally and nationally. This work is being undertaken within the context of an organisation-wide strategic review, which includes consideration of the management of public health priorities to ensure Public Health England can fulfil its role of leading the public health system and deliver its responsibilities in the most efficient and effective way.</p> <p>Set in this context, escalation procedures have been updated and will be finally outlined within updated operational guidance for Public Health England Centres, aimed at improving the quality and consistency of the advice and support Public Health England Centres offer to provider organisations in relation to healthcare associated infections. Public Health England's operational guidance has been re-written to reflect the changes to structures within the health and social care sector in England and to outline the requirements relating to the Antimicrobial Resistance agenda. It is currently being prepared for internal consultation with a view to publication before the end of March 2015. Public Health England's work to update this operational guidance will be further finessed by the recommendations resulting from its own internal strategic review. This document encompasses the updated escalation algorithm and is scheduled for publication by end of March 2015. Public Health England is also considering how it will integrate proportionate expert support into the escalation process as requested or deemed necessary according to the level of concern.</p> <p>Additionally, Public Health England is working to integrate this approach into a high-level overview of the escalation steps in relation to sharing concerns about healthcare associated infections aligned to incident levels within Public Health England's National Incident Response Plan. This work is being undertaken with partners, including the Department of Health, NHS England, the Care Quality Commission, Monitor and the NHS Trust Development Authority. Public Health England will continue to monitor the agreed ways of working between the organisations and undertake work to strengthen, these informed by any changes or recommendations arising from its strategic review.</p>
108	<p>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.</p>	<p>Accepted.</p> <p>Public Health England recognises the importance of supporting local infection control and prevention arrangements, and has undertaken a review. Although the offer of support and training would be a significant undertaking, Public Health England is considering options as to how it will be able to provide this in the future and is discussing these with the Department of Health.</p>	<p>Public Health England is continuing to work with partners working across the Health Protection Directorate, the Nursing Directorate and the Operations Directorate to explore options to improve training.</p> <p>Public Health England is currently triangulating work across three of its Directorates (Health Protection, Operations and Nursing) to develop a training strategy to facilitate support and training for Local Authorities and other agencies (stakeholders) in relation to both the local oversight and risk assessment of healthcare providers' infection control arrangements.</p> <p>A position statement and proposals for the High Level Steering Group for the UK 5 year Antimicrobial Resistance Strategy outlining Infection Prevention and Control in England – Proposals to revisit structures and functions, principles and practice was submitted on 18 July 2014 with an emphasis on education, training and leadership.</p> <p>A report of the Public Health England-led multi-stakeholder Antimicrobial</p>

			<p>Resistance Strategy Systems Mapping Workshop held on the 08 July 2014 outlined the development of a national training and education framework for professionals for Infection Prevention and Control and antibiotic resistance, focusing on establishing strong national and local leadership and governance for Infection Prevention and Control across the health and care sector.</p> <p>The Public Health England Operational Directorate (via the Public Health England Centre Antimicrobial Resistance and Healthcare Associated Infections leads group) is developing a 'train the trainers' programme outlining the roles and responsibilities of Public Health England Centres there Local Authorities and other Stakeholders. This will be by the end of the financial year and will be aligned with the revision of the Public Health England internal Healthcare Associated Infections and Antimicrobial Resistance Operational Guidance for Public Health England Centres, the cross-organisational 'Overarching Principles for Sharing Concerns' and the revision of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2010) . The training programme will cover local oversight of infection prevention and control for local authorities and other agencies using risk assessment, epidemiological principles, infection surveillance data and softer intelligence. The training programme will utilise existing local and national data combined with local knowledge and will be developed and disseminated through Health Protection Teams using the available resources and by working with their health communities (Quality surveillance Groups, Health and Well-being Groups and Infection Prevention and Control committees). This will contribute to a consistent approach across all Public Health England Centres and their localities.</p>
109	<p>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.</p>	<p>Accepted.</p> <p>Feedback of any kind, but particularly concerns and complaints, are important; they enable things to be put right for the complainant and drive the improvement of hospital services. But there is evidence that not everyone who would wish to make a complaint does so. This can be for a number of reasons, of which ease of access to the complaints arrangements is an important one.</p> <p>The overall framework for complaints handling is laid down in regulation and it is important that the overall process is consistent across the NHS and clear to patients.</p> <p>The Government wants to see every Trust make clear to every patient from their first encounter with the hospital:</p> <ul style="list-style-type: none"> • How they can complain to the hospital when things go wrong • Who they can turn to for independent local support if they want it, and where to contact them • That they have the right to go to the Ombudsman if they remain dissatisfied, and how to contact them; and • Details of how to contact their local HealthWatch. <p>A sign in every ward and clinical setting would be a simple means of achieving this and the Department will be discussing with Healthwatch England, Care Quality Commission and NHS England the best means of ensuring this becomes standard practice in all NHS hospitals in England. We would expect these posters to set out how to complain about</p>	<p>The Department of Health made a complaints poster template available to the NHS at the end of November 2014.</p> <p>The Parliamentary and Health Service Ombudsman working with Healthwatch England and the Local Government Ombudsman published universal expectations for raising concerns and complaints to support improvements in complaint handling. The user led vision and expectations represent a comprehensive guide to how a good experience of raising a concern or complaint should look and feel.</p> <p>For the person who has raised a concern or complaint, the ultimate vision is for them to be able to describe their experience as: "I felt confident to speak up and making my complaint was simple. I felt listened to and understood. I felt that my complaint made a difference." The expectations provide a tangible way to measure the extent to which the expectations of users of health and social care services are being met through the complaints arrangements. .</p> <p>The Department of Health and NHS England together are issuing an accessible feedback and complaints guide for patients who wish to give feedback or that are dissatisfied with the service they have received from the NHS. The guide will provide information on how to raise a concern or to make a complaint. This will support the NHS Constitution which sets out patients' right to complain about their NHS care, should they wish, and will be published on the NHS Constitution page of the Gov.uk website.</p> <p>Creating an environment whereby complaints are encouraged across the NHS will take time, but the Government and its national partners are seeing substantial progress being made in a variety of areas. One example of progress in the patient's access to complain is the Lancashire Teaching Hospitals NHS Foundation Trust. Information and awareness of how to provide feedback/make a complaint is emphasised in the Trust through installation of a suite of posters widely displayed in public areas; information leaflets that are available in all areas; and information on the Trust's websites, both internally and externally</p>

		<p>hospital, how to seek support from their local Healthwatch and how to refer their complaint to the Ombudsman.</p> <p>It is important that local Healthwatch, as the patient and public champion for health and care services, should be as strong and effective as possible so that it can speak up for patients and provided independent support on complaints. The Department of Health supports Healthwatch England in their plans to coordinate a consumer-facing complaints campaign with their partners. This will help ensure there is better quality information for patients about how to raise a concern and the standards they should expect if they make a complaint.</p> <p>The Department of Health wants to see patient advice and liaison services well-sign posted, funded and staffed in every hospital so patients can go and share a concern with someone else in the hospital if they do not feel confident talking to their nurse or doctor on the ward. The Department agrees it is appropriate to review the patient advice and liaison services, and will undertake to begin that work in 2014.</p> <p>Furthermore Rt Hon Ann Clwyd MP and Professor Tricia Hart's Review of the Handling of Complaints in NHS Hospitals makes two recommendations on good practice to support patients who have some dissatisfaction with their healthcare that would assist in the delivery of this recommendation:</p> <ul style="list-style-type: none"> • Trusts should provide patients with a way of feeding back comments and concerns about their care on the ward, including simple steps such as putting pen and paper by the bedside, and making sure patients know who to speak to if they have a concern – this could be a nurse or a doctor, or a volunteer on the ward; • Hospitals should actively encourage and use volunteers to support patients in expressing concerns or complaints. This is particularly important where patients are vulnerable or alone, when they might find it difficult to raise concerns at the time the problem arises: volunteers should be regularly refreshed. <p>As part of its new inspection regime, the Care Quality Commission will be including complaints handling in its assessment of Trust performance which includes how Trusts have learnt from complaints.</p>	<p>facing. In addition, satisfaction questionnaires included with each complaint response in which the complainant is asked to provide feedback on the complaints process, the quality of the response letter, and whether it satisfactorily answers their queries and concerns ensures that the Trust maintains a certain level of quality in its complaints processes. While these methods of patient complaint are not nationwide as of yet, Lancashire Teaching Hospitals NHS Foundation Trust testifies that a positive cultural change, which welcomes negative feedback, is beginning to take place within the nation's healthcare environments.</p> <p>Complaints are a key line of inquiry for the Care Quality Commission in all health and social care inspections as part of the "responsive" domain.</p>
110	<p>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 consideration of litigation.</p>	<p>Accepted.</p> <p>The NHS Litigation Authority actively promotes openness, transparency and candour and has long advocated that it is appropriate to apologise when things go wrong and to provide a full explanation in response to a concern. The NHS Litigation Authority is clear that providing an apology and an explanation in response to a concern will not affect member's indemnity cover, irrespective of whether this forms part of the complaints process.</p> <p>Prior to April 2009, where a complaint was received about which the complainant had indicated in writing that they were intending to take legal proceedings, the complaint was excluded from the NHS complaints arrangements. In 2009, the Department of Health removed this regulation because it considered there should be no direct link between responding to a complaint and consideration of litigation. In some cases, it will be appropriate for the complaint to be put on hold, but that should be an exception.</p> <p>The Department of Health will work with Action Against Medical Accidents (AvMA) and NHS England to clarify that a threat of future litigation should not delay the</p>	<p>The Department of Health, working closely with Action against Medical Accidents and NHS England published clarification on this in March 2014</p>

		handling of a complaint.	
111	<p>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.</p>	<p>Accepted.</p> <p>Feedback, of which complaints are an important part, is a strong indicator of patient experience, and serves to assist organisations to improve service delivery. It should be encouraged and welcomed as a matter of good practice.</p> <p>The Review of the Handling of Complaints in NHS Hospitals and the Inquiry showed that complaints should be dealt with fairly and lessons learned when things go wrong. The emphasis is rightly on hospital Boards and Chief Executives to correct their mistakes, explain to patients what went wrong, and show how they will put it right. The management of an effective system of complaints and patient feedback is a Board level responsibility. An effective Trust Board will promote a culture of openness, recognise the value of patient comments and complaints, and make it easy for patients, their families and carers to give feedback. An effective Trust Board will also be open about and publish regular information about the complaints it receives and the action it is taking as a result.</p> <p>The Government wants to see every Trust make clear to every patient from their first encounter with the hospital:</p> <ul style="list-style-type: none"> • How they can complain to the hospital when things go wrong • Who they can turn to for independent local support if they want it, and where to contact them • That they have the right to go to the Ombudsman if they remain dissatisfied, and how to contact them; and • Details of how to contact their local HealthWatch. <p>A sign in every ward and clinical setting would be a simple means of achieving this and the Department will be discussing with Healthwatch England, Care Quality Commission and NHS England the best means of ensuring this becomes standard practice in all NHS hospitals in England. We would expect these posters to set out how to complain about hospital, how to seek support from their local Healthwatch and how to refer their complaint to the Ombudsman.</p> <p>It is important that local Healthwatch, as the patient and public champion for health and care services, should be as strong and effective as possible so that it can speak up for patients and provided independent support on complaints. The Department of Health supports Healthwatch England in their plans to coordinate a consumer-facing complaints campaign with their partners. This will help ensure there is better quality information for patients about how to raise a concern and the standards they should expect if they make a complaint.</p> <p>The Review of the Handling of Complaints in NHS Hospitals recommends the following:</p> <ul style="list-style-type: none"> • Trusts should actively encourage both positive and negative feedback about their services. Complaints should be seen as essential and helpful information, and welcomed as necessary for continuous service improvement. • Trusts should provide patients with a way of feeding back comments and concerns about their care on the ward, including simple steps such as putting pen and paper by the bedside, and making sure patients know who to speak to if they have a concern – this could be a nurse or a doctor, or a volunteer on the ward to 	<p>Sir Mike Richard's thematic complaints report <i>Complaints Matter</i> was published in December 2014. It covers acute inspections, primary care, and social care and identifies trends and themes in complaints handling drawn from the inspections done by the Care Quality Commission.</p> <p>Monitor is in the process of working to further align the well-led framework with the Care Quality Commission's new inspection regime. The current well-led <u>framework</u> was published in May 2014 and includes a number of references to how boards should use complaints in reviewing their governance arrangements. The framework will be used by NHS Trusts, Foundation Trusts, Monitor, NHS Trust Development Authority and the Care Quality Commission to ensure consistent standards across the system of how well-led NHS organisations are.</p> <p>The Department of Health is working with NHS England to strengthen the 15/16 NHS Standard contract so it includes the need to prominently display complaints information.</p> <p>Looking at whether patients can leave feedback easily has been a component of the new the Care Quality Commission inspections since October 2014. Complaints is a key line of enquiry in the Care Quality Commission inspections, and this includes looking at a random sample of closed complaints to see how they were investigated, and to look at how the Trust learnt from the complaint and embedded the change in the organisation. The Care Quality Commission will also look at the ward environment. Within the inspections, the Care Quality Commission will look at whether the method of investigating the complaint is appropriate for the issue involved i.e. that in serious cases, independent investigation was conducted.</p>

		<p>help people.</p> <ul style="list-style-type: none"> Hospitals should actively encourage volunteers. Volunteers can help support patients who wish to express concerns or complaints. This is particularly important where patients are vulnerable or alone, when they might find it difficult to raise a concern. Volunteers should be trained. <p>As part of its new inspection regime, the Care Quality Commission will be including complaints handling in its assessment of Trust performance, looking at how they have learnt lessons and what action they have taken as a result.</p>	
112	<p>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</p>	<p>In many respects, the distinction between a 'concern' and a 'complaint' is artificial. Both indicate some level of dissatisfaction and require a response. Patients or their relatives will often feel more comfortable in raising a concern than in making a complaint, but a concern may be just as likely to indicate a potential patient safety issue. It is important that concerns and complaints are handled in accordance with the needs of the individual case, and investigated.</p>	<p>Sir Mike Richard's thematic complaints report <i>Complaints Matter</i> was published in December 2014. It covers acute inspections, primary care, and social care and identifies trends and themes in complaints handling drawn from the inspections done by the Care Quality Commission.</p> <p>Monitor is in the process of working to further align the well-led framework with the Care Quality Commission's new inspection regime. The current well-led <u>framework</u> was published in May 2014 and includes a number of references to how boards should use complaints in reviewing their governance arrangements. The framework will be used by NHS trusts, Foundation trusts, Monitor, NHS Trust Development Authority and the Care Quality Commission to ensure consistent standards across the system of how well-led NHS organisations are.</p> <p>At their 2014 Annual Conference, the NHS Confederation dedicated a session on capturing the patient perspective to improve care. The session looked at good practice examples of organisations effectively gathering and using feedback to improve services and how the NHS can make the most of this invaluable information to deliver patient-centred healthcare.</p> <p>At their 2015 Annual Conference, the NHS Confederation will have the patient voice and experience as a central theme.</p>
113	<p>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.</p>	<p>Accepted.</p> <p>At present, standards of complaints handling are judged on the basis of the 2009 regulations and the Health Service Ombudsman's <i>Principles of Good Complaints Handling</i>. While both of these remain important, a more formal statement of standards is likely to be of benefit to the NHS, whether complaints managers and Trust Boards at local level, or regulators.</p> <p>The <u><i>Review of the Handling of Complaints in NHS Hospitals</i></u> recommends that:</p> <ul style="list-style-type: none"> Commissioners and regulators establish clear standards for hospitals on complaints handling. These should rank highly in the audit and assessment of the performance of all hospitals. <p>The Government has asked the Parliamentary and Health Service Ombudsman and Healthwatch England, working with the Department of Health, to develop a patient-led vision and expectations for complaints handling in the NHS. The Parliamentary and Health Service Ombudsman, Healthwatch England and the Department of Health will work with the Patients Association, patients, regulators, commissioners and providers to develop universal expectations for complaints handling. These will be used across the NHS to drive improvements in patient satisfaction with complaint handling. The vision and expectations will inform:</p> <ul style="list-style-type: none"> Patients about what to expect when they make a complaint about NHS services The work of the Healthwatch network in challenging local providers to improve their practices 	<p>The Parliamentary and Health Service Ombudsman, working with Healthwatch England and the Local Government Ombudsman, <u>published</u> universal expectations for raising concerns and complaints to support improvements in complaint handling in November 2014. The user led vision and expectations represent a comprehensive guide to how a good experience of raising a concern or complaint should look and feel.</p> <p>For the person who has raised a concern or complaint, the ultimate vision is for them to be able to describe their experience as: "I felt confident to speak up and making my complaint was simple; I felt listened to and understood; I felt that my complaint made a difference." The expectations provide a tangible way to measure the extent to which the expectations of users of health and social care services are being met through the complaints arrangements.</p> <p>This work will inform the Care Quality Commission inspections to help to assess to what extent the service is responsive.</p>

		<ul style="list-style-type: none"> • Providers and commissioning bodies about what they can do to use patient concerns and complaints to improve services and how they can measure their own progress • Regulatory assessment of hospital complaint handling • The Parliamentary and Health Service Ombudsman investigation of complaints about NHS services brought to them by patients and their families. 	
114	Comments or complaints which describe events amounting to a serious or untoward incident should trigger an investigation.	<p>Accepted.</p> <p>A fundamental principle of the current complaints arrangements for handling NHS and adult social care complaints is that a case should be handled according to the needs of that individual case. Investigation should be proportionate to the needs of the case, but any concern about patient safety needs to be robustly investigated. The Department of Health strongly agrees that complaints amounting to a serious or untoward incident warrant independent local investigation and we want to see all NHS Trusts using their statutory powers to offer this to patients.</p> <p>NHS England's guidance <i>The Serious Incident Framework</i> sets out how Serious Incidents should be managed. It states that 'Initial incident grading should err on the side of caution, categorising and treating an incident as a serious incident if there is any possibility that it is.' Furthermore it states that 'All serious incidents should be investigated using best practice methodologies such as root cause analysis.' Any complaint alleging that a Serious Incident has occurred should therefore be investigated. The Care Quality Commission already uses a range of information about complaints to inform the timing and focus of its inspections, and through the Chief Inspectors, is currently exploring how it can give greater prominence to complaints and safety alerts in its revised surveillance and inspection model.</p> <p>The definition of a Serious Incident is:</p> <ul style="list-style-type: none"> • an incident that occurred during NHS funded healthcare (including in the community), which resulted in one or more of the following: <ul style="list-style-type: none"> • unexpected or avoidable death or severe harm of one or more patients, staff or members of the public; • a never event – all never events are defined as serious incidents although not all never events necessarily result in severe harm or death; • a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population; • allegations, or incidents, of physical abuse and sexual assault or abuse; and/or • loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation. <p>The current NHS England Serious Incident Framework is a working draft and will therefore be updated and clarified in relation to this recommendation.</p>	<p>NHS England's guidance <i>The Serious Incident Framework</i> sets out how Serious Incidents should be managed. NHS England is reviewing the Serious Incident Framework, but it agrees it is important that the level of investigation required following a serious incident will vary according to the severity of the incident. In some circumstances, fully independent investigation by an external team will be appropriate.</p> <p>NHS England will be publishing an update of the Serious Incident Framework in due course.</p>
115	Arms length independent investigation of a complaint should be initiated by	Accepted in part.	The Department of Health agrees there needs to be communication to the NHS,

<p>the provider trust where any one of the following apply:</p> <ul style="list-style-type: none"> • 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. 	<p>Investigation of any complaints should be proportionate to the needs of the individual case. This follows the fundamental principle that complaints cases should be handled according to the needs of that individual case. In serious or complex complaints, the investigator may often be expected to be from outside the organisation being complained about.</p> <p>Where a serious incident is alleged via a complaint, it must be treated as a serious incident identified through any other means until the incident has been investigated, responded to and closed or the investigation reveals the allegation is not supported by the evidence. Investigation of incidents by fully independent teams from outside an organisation are extremely useful for ensuring that the lessons from an incident are identified, learned and relevant actions initiated to prevent recurrence, particularly in the case of very complex, sensitive or wide-ranging serious incidents. It is an important principle, however, that serious incident investigations should be proportionate to the severity of the incident in question, given the resources involved in a full independent investigation and the length of time they can take.</p> <p>NHS England has published a Serious Incident Framework, which sets out the various types of investigation that must be undertaken following a serious incident. This makes clear that the level of investigation required following a serious incident will vary according to the severity of the incident. The need for independent investigation must be determined in conjunction with the relevant commissioner. Investigations for less severe serious incidents can be undertaken by organisations themselves provided the staff undertaking the investigation are sufficiently removed from the incident to be able to provide an objective view and that there is no conflict of interest, real or perceived.</p> <p>Regarding the need for an expert clinical opinion, the <i>Review of the Handling of Complaints in NHS Hospitals</i> raises the issue of a need for a greater degree of independence at local level, and makes a recommendation that supports this general approach:</p> <ul style="list-style-type: none"> • When Trusts have a conversation with patients at the start of the complaints process on a serious failing in care they should immediately offer truly independent clinical and lay advice... to the complainant. <p>However, we consider there to be an important distinction between an independent investigation and an expert clinical opinion. An independent investigation seeks to determine the facts of the case. They will seek the views of an expert clinician, where appropriate. Independent investigation should be determined on the nature of the complaint, with serious failings in particular warranting independent investigation.</p> <p>Similarly, we do not consider it appropriate for independent investigation to take place in all cases. The complaints manager in each Trust should be sufficiently senior and competent to be able to judge effectively when a complaint merits independent advice or investigation.</p> <p>Depending on the nature of a complaint, fully independent investigation of the serious incident by an external team may be appropriate. However in some cases, particularly where it is not clear that a serious incident has occurred, it is appropriate, particularly in the initial phase, for an organisation to undertake its own investigation using staff sufficiently removed from the incident with no conflict of interest, until such a time as the facts require an independent investigation to be commissioned. The current NHS England Serious Incident Framework is a working draft and will therefore be updated and clarified in relation to this recommendation.</p> <p>If the person making the complaint is not satisfied with the outcome at this local resolution stage, they have the right to ask the Health Service Ombudsman to investigate the case. The Ombudsman is independent of Government and the NHS,</p>	<p>and Board level management, emphasising the importance of learning from mistakes, showing evidence of improvement and Board directors considering complaints regularly.</p> <p>Monitor is in the process of working to further align the well-led framework with the Care Quality Commission's new inspection regime. The current well-led <u>framework</u> was published in May 2014 and includes a number of references to how Boards should use complaints in reviewing their governance arrangements. The framework will be used by NHS Trusts, Foundation Trusts, Monitor, NHS Trust Development Authority and the Care Quality Commission to ensure consistent standards across the system of how well-led NHS organisations are.</p> <p>Sir Mike Richard's thematic complaints report <i>Complaints Matter</i> was published in December 2014. It covers acute inspections, primary care, and social care and identifies trends and themes in complaints handling drawn from the inspections done by the Care Quality Commission.</p>
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116	<p>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.</p>	<p>Accepted.</p> <p>People making complaints can feel isolated and intimidated when in meetings with complaints managers and trust representatives. Some patients, relatives or friends remain deeply affected by their experiences. It is right that support is available, particularly where there may have been a serious failing in care, not only to help them navigate through the process but also for someone to be there to speak for them.</p> <p>Local Authorities are responsible for commissioning NHS complaints advocacy services, and are able to determine the appropriate model of delivery for these services for their local community. The Department of Health considers the recommendations above to be best practice and the best local advocacy services will provide support that complainants can access easily, and that meets their needs.</p> <p>NHS Trusts, and particularly the Patient Advice and Liaison Services within those Trusts, will be aware of the NHS complaints advocacy providers within their areas. It is right that they publicise these arrangements for people who have made a complaint or who are thinking of making one. The Department of Health wants to see patient advice and liaison services well-sign posted, funded and staffed in every hospital so patients can go and share a concern with someone else in the hospital if they do not feel confident talking to their nurse or doctor on the ward. The Department agrees it is appropriate to review the patient advice and liaison services, and will undertake to begin that work in 2014.</p> <p>The Government wants to see every Trust make clear to every patient from their first encounter with the hospital:</p> <ul style="list-style-type: none"> • How they can complain to the hospital when things go wrong • Who they can turn to for independent local support if they want it, and where to contact them • That they have the right to go to the Ombudsman if they remain dissatisfied, 	<p>The Department of Health, with key partners, will consider different aspects of Patient Advice and Liaison Services and identify if there are any areas where more substantial work may need to be commissioned to gain a better understanding. Work on this project has started, and it is envisaged the initial review and identification of areas for more detailed consideration, will be complete by Spring 2015.</p> <p>The Health and Social Care Act 2012 gave responsibility for commissioning NHS complaints advocacy to individual Local Authorities from April 2013. The Clwyd/Hart Review of the handling of NHS complaints recommended that “the independent NHS Complaints Advocacy Service should be re-branded, better resourced and publicised. It should also be developed to embrace greater independence and support to those who complain. Funding should be protected and the service attached to local Healthwatch organisations.” The Government accepted that a review of NHS complaints advocacy services should be conducted to measure the effectiveness of the provision of advocacy services to the public. This review is expected to be complete by Spring 2015.</p> <p>Healthwatch England have also developed a set of national standards for complaints advocacy services, generated from workshops and interviews with people who use advocacy services.</p>

		<p>and how to contact them; and</p> <ul style="list-style-type: none"> • Details of how to contact their local HealthWatch. <p>A sign in every ward and clinical setting would be a simple means of achieving this and the Department will be discussing with Healthwatch England, Care Quality Commission and NHS England the best means of ensuring this becomes standard practice in all NHS hospitals in England. We would expect these posters to set out how to complain about hospital, how to seek support from their local Healthwatch and how to refer their complaint to the Ombudsman.</p> <p>The <i>Review of the Handling of Complaints in NHS Hospitals</i> made the following recommendations:</p> <ul style="list-style-type: none"> • When Trusts have a conversation with patients at the start of the complaints process on a serious failing in care they should immediately offer truly independent clinical and lay advice and independent advocacy support to the complainant; and • Hospitals should actively encourage volunteers. Volunteers can help support patients who wish to express concerns or complaints. This is particularly important where patients are vulnerable or alone, when they might find it difficult to raise a concern. Volunteers should be trained. 	
117	A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.	<p>Accepted in part.</p> <p>We agree that expert advice should be provided in appropriate cases, and in appropriate cases, the providers of NHS complaints advocacy would obtain advice from an independent clinical expert. However complaints advocacy services are no longer commissioned nationally. From April 2013, Local Authorities have been responsible for commissioning NHS complaints advocacy services, and are able to determine the appropriate model of delivery for these services for their local community.</p> <p>We consider that the need for expert clinical advice ought not to be determined by how complicated a case might be, but whether it is appropriate in the individual case. In those cases, the trust should offer that advice, along with independent investigation.</p> <p>The <i>Review of the Handling of Complaints in NHS Hospitals</i> recommends:</p> <ul style="list-style-type: none"> • When Trusts have a conversation with patients at the start of the complaints process they must ensure the true independence of the clinical and lay advice and advocacy support offered to the complainant. <p>The Department of Health will work with Healthwatch England and the Local Government Association to develop a set of 'good practice' standards for NHS Complaints advocacy services; these standards may be expected to include access to clinical advice in appropriate cases.</p>	<p>The Department of Health, with key partners, will consider different aspects of PALS and identify if there are any areas where more substantial work may need to be commissioned to gain a better understanding. Work on this project has started, and it is envisaged the initial review and identification of areas for more detailed consideration, will be complete by Spring 2015.</p> <p>The Health and Social Care Act 2012 gave responsibility for commissioning NHS complaints advocacy to individual Local Authorities from April 2013. The Clwyd/Hart Review of the handling of NHS complaints recommended that "the independent NHS Complaints Advocacy Service should be re-branded, better resourced and publicised. It should also be developed to embrace greater independence and support to those who complain. Funding should be protected and the service attached to local Healthwatch organisations." The Government accepted that a review of NHS complaints advocacy services should be conducted to measure the effectiveness of the provision of advocacy services to the public. This review is expected to be complete by Spring 2015.</p> <p>Healthwatch England have also developed a set of national standards for complaints advocacy services, generated from workshops and interviews with people who use advocacy services.</p>
118	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the	<p>Accepted in part.</p> <p>An open culture demands that information is available to service users, their families and carers to enable them to make informed choices about their healthcare.</p> <p>Trusts currently have to publish an annual report on complaints handling. This report contains information on the number of complaints received, the number referred to</p>	<p>It is important for organisations to be accountable to the public for the way they handle complaints. The Department of Health, working with the Health and Social Care Information Centre, committed to developing a system that enabled Trusts to publish accurate, detailed quarterly data on the number of complaints received, and to enable comparison across hospitals. The overall aim of the revisions is to provide members of the public and regulatory bodies with frequent, more meaningful data which will identify organisations whose level of complaints, whether high or low, suggests there may be cause for concern.</p>

	<p>summary should be shared confidentially with the Commissioner and the Care Quality Commission.</p>	<p>the Health Service Ombudsman, and a summary of the subject matter of those complaints, any matters arising from them, and any matters where action has been taken (or will be taken) as a result of the complaint. These reports are sent to the commissioning body, and made available to anyone who requests one, but the Government believes we can go further.</p> <p>Rt Hon Ann Clwyd MP and Professor Tricia Hart's <u>Review of the Handling of Complaints in NHS Hospitals</u> recommends that:</p> <ul style="list-style-type: none"> • There should be Board- led scrutiny of complaints. All Boards and Chief Executives should receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action. These reports should be available to the Chief Inspector of Hospitals. <p>The Department of Health will ensure that each quarter every hospital publishes information on the complaints it has received. This will include:</p> <ul style="list-style-type: none"> • the number of complaints received, as a percentage of patient interventions in that period; • the number of complaints the hospital has been informed have subsequently been referred to the Ombudsman; and • lessons learned and improvements made as a result of complaints. <p>The Department of Health will work with NHS England and other key partners to determine the most effective mechanism through which to achieve these outcomes. The Chief Inspector and Care Quality Commission will require regular reporting of complaints from all providers to inform its surveillance and risk profiling regime. Care Quality Commission will naturally be particularly interested in complaints concerning death, serious injury or 'near misses' but will also want to harness information about other aspects of patient experience and concern which would be indicative of trust culture and performance. Care Quality Commission will be discussing with Monitor, Trust Development Authority and providers a proportionate and cost- effective means of doing so.</p> <p>The Department would wish to reconsider this recommendation in relation to complaints of a serious nature, and making them available in a wider range of formats, once an agreed and consistent standard exists against which to judge the handling of an individual complaint. This would lead to more consistency in outcomes.</p>	<p>Hospitals will begin revised collections from April 2015, with the first quarterly report envisaged by late summer 2015. It is expected the public can begin to compare Trusts' complaints data by late Autumn 2015.</p> <p>The Department of Health is working with NHS England to strengthen the 15/16 NHS Standard contract so it includes the need to prominently display complaints information.</p> <p>Sir Mike Richard's thematic complaints report was published in December 2014. It covers acute inspections, primary care, and social care and identifies trends and themes in complaints handling drawn from the inspections done by the Care Quality Commission.</p>
119	<p>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.</p>	<p>Accepted.</p> <p>Complaints data, along with other sources of feedback, have the potential to provide important information to local Healthwatch Organisations and Overview and Scrutiny Committees. It is important that Trusts respect patient confidentiality when releasing information on complaints to outside organisations but, subject to this caveat, we consider that Trusts should seek to provide to these organisations with the complaints data that are requested.</p> <p>The Department of Health will ensure that each quarter every hospital publishes information on the complaints it has received. This will include:</p> <ul style="list-style-type: none"> • the number of complaints received, as a percentage of patient interventions in that period; • the number of complaints the hospital has been informed have 	<p>The Department of Health, working with the Health and Social Care Information Centre, committed to developing a system that enabled Trusts to publish accurate, detailed quarterly data on the number of complaints received, and to enable comparison across hospitals.</p> <p>The overall aim of the revisions is to provide members of the public and regulatory bodies with frequent, more meaningful data which will identify organisations whose level of complaints, whether high or low, suggests there may be cause for concern.</p> <p>Hospitals will begin revised collections from April 2015, with the first quarterly report envisaged by late summer 2015. It is expected the public can begin to compare Trusts' complaints data by late Autumn 2015.</p>

		<p>subsequently been referred to the Ombudsman; and</p> <ul style="list-style-type: none"> lessons learned and improvements made as a result of complaints. <p>The Department of Health will work with NHS England and other key partners to determine the most effective mechanism through which to achieve these outcomes. Rt Hon Ann Clwyd MP and Professor Tricia Hart's <u>Review of the Handling of Complaints in NHS Hospitals</u> recommends that:</p> <ul style="list-style-type: none"> There should be Board-led scrutiny of complaints. All Boards and Chief Executives should receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action. These reports should be available to the Chief Inspector of Hospitals. Patients, patient representatives and local communities and local Healthwatch organisations should be fully involved in the development and monitoring of complaints' systems in all hospitals. <p>Local Healthwatch has an important role to play as patient champion, and it is right that individual local Healthwatch organisations have access to detailed information about complaints, subject to respect for patient confidentiality. Local Healthwatch have an important role to play in scrutinising complaints data locally.</p> <p>The Department of Health will work with the Health and Social Care Information Centre to put complaints data into the existing NHS electronic data collection system, better enabling comparison between hospitals.</p>	
120	<p>Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so.</p>	<p>Accepted in part.</p> <p>We accept that commissioning bodies play an important role in ensuring that the organisations from which it commissions services are delivering effective and open complaints arrangements, and delivering their statutory responsibilities. Complaints contain valuable information that commissioners should be aware of. However, we consider requiring Trusts to provide all complaints information will place a significant bureaucratic burden on both the service provider and the commissioning body. To be meaningful, commissioners would need to be aware of, and understand each complaint, which would also be an unjustifiable duplication of resources.</p> <p>The <u>Review of the Handling of Complaints in NHS Hospitals</u> recommends that:</p> <ul style="list-style-type: none"> There should be Board-led scrutiny of complaints. All Boards and Chief Executives should receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action. These reports should be available to the Chief Inspector of Hospitals. <p>The Department of Health will ensure that each quarter every hospital publishes information on the complaints it has received. This will include:</p> <ul style="list-style-type: none"> the number of complaints received, as a percentage of patient interventions in that period; the number of complaints the hospital has been informed have subsequently been referred to the Ombudsman; and 	<p>It is important for organisations to be accountable to the public for the way they handle complaints. The Department of Health, working with the Health and Social Care Information Centre, committed to developing a system that enabled Trusts to publish accurate, detailed quarterly data on the number of complaints received, and to enable comparison across hospitals. The overall aim of the revisions is to provide members of the public and regulatory bodies with frequent, more meaningful data which will identify organisations whose level of complaints, whether high or low, suggests there may be cause for concern. Hospitals will begin revised collections from April 2015, with the first quarterly report envisaged by late summer 2015. It is expected the public can begin to compare Trusts' complaints data by late Autumn 2015.</p> <p>The Department of Health is working with NHS England to strengthen the 15/16 NHS Standard contract so it includes the need to prominently display complaints information.</p> <p>Sir Mike Richard's thematic complaints report was published in December 2014. It cover acute inspections, primary care, and social care and identifies trends and themes in complaints handling drawn from the inspections done by the Care Quality Commission.</p>

		<ul style="list-style-type: none"> lessons learned and improvements made as a result of complaints. <p>The Department of Health will work with NHS England and other key partners to determine the most effective mechanism through which to achieve these outcomes.</p>	
121	<p>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.</p>	<p>Accepted.</p> <p>Information received from people who use care services about the quality and safety of their care, including concerns and complaints, is a vital source of information which needs to be available to the regulator. The Care Quality Commission accesses and uses a range of information about complaints to inform the timing and focus of its inspections. This information ranges from aggregated numbers and patterns of complaints, to individuals who contact the Care Quality Commission and tell inspectors about their experience. The Care Quality Commission participates in the Quality Surveillance Groups that have been established in each area. These groups actively share between commissioners, regulators, all local NHS organisations and others, information and intelligence on the quality of care being delivered</p> <p>The new approach to inspection that the Care Quality Commission has introduced places a stronger focus on how care is delivered in practice and how it is experienced, rather than just compliance with regulations. In line with this, the Care Quality Commission is now making greater use of the information that it has on complaints.</p> <p>In light of the recommendations made in <i>Review of the Handling of Complaints in NHS Hospitals</i> the Care Quality Commission will review how it makes best use of the complaints that it receives directly from individuals, and the individual stories in complaints, as well as the aggregated trends. As it continues to test and engage on refining its new approach to inspection between now and April 2014, it will also review whether or not routinely to require of providers a report on complaints, self-assessment or other form of declaration, to inform its monitoring and inspections. This consideration will be coordinated with other information requirements on providers, and decided in light of the NHS Confederation's <i>Review of Bureaucracy in the NHS</i>.</p> <p>The Department of Health will work with the Care Quality Commission to ensure that its new surveillance model for monitoring risk at NHS acute hospitals includes information on complaints handling.</p>	<p>Quality Surveillance Groups exist to identify risks to quality at as early a stage as possible, by actively sharing information and intelligence between commissioners, regulators and those with a system oversight role. Quality Surveillance Groups support cooperation between different parts of the system to safeguard the quality of care patients receive.</p> <p>The quality of complaints handling by a provider is now a key component of the Care Quality Commission's inspection programme. The Care Quality Commission have reached outside the organisation to draw on expertise from those who have experienced the complaints system, and been a "whistleblower". This includes employing James Titcombe as their National Patient Safety Advisor and Dr Kim Holt as an advisor in developing proposals to test how providers manage staff concerns.</p>
122	<p>Large-scale failures of clinical service are likely to have in common a need for:</p> <ul style="list-style-type: none"> 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; 	<p>Accepted in principle.</p> <p>We agree that in the rare circumstances that significant failures are identified as part of regulatory action, part of the response to that failure will be the consideration of advice and information to the public about the nature of that failure and potential support to those directly affected by the issues identified. However, while we also agree that such a response needs clear coordination across a number of involved organisations we do not agree that this should be a function of the National Quality Board. Rather such action should be part of a response to the single failure regime outlined in recommendation 19 and be agreed jointly between the trust, Care Quality Commission, Monitor and the NHS Trust Development Authority as appropriate to ensure that all those directly involved in the identified failure are work together through that regime.</p>	<p>No longer is inadequate care left unaddressed. Where the Care Quality Commission identifies poor care and weak leadership it recommends that an NHS or Foundation Trust is placed in special measures. Monitor and the NHS Trust Development Authority will then decide whether to do so, and may also put Trusts in special measures based on its own evidence without waiting for the Chief Inspector's recommendation. Monitor and the NHS Trust Development Authority will typically undertake a number of interventions to improve performance and require the Trust to publish progress against an action plan every month.</p> <p>The Trust will then be re-inspected by the Care Quality Commission after twelve months to assess progress. Following Professor Sir Bruce Keogh's review into hospitals with high mortality rates, eleven hospitals were put into special measures, and have been provided with extra support from Monitor and the NHS Trust Development Authority.</p> <p>A further eight Trusts have been placed in special measures after a Care Quality</p>

	<ul style="list-style-type: none"> • 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. <p>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.</p>	<p>The Care Quality Commission, Monitor and the NHS Trust Development Authority will work together to publish further guidance, as soon as possible after April 2014, to provide further detail on how these organisations work together to address risks to quality. This will include details of how concerns, including immediate concerns, will be addressed, how and when the single failure regime could be triggered and what guidance and support would be made available to the public in the event of large scale, significant, failure. This guidance will build on the joint policy statement, <i>The Regulation and oversight of NHS Trusts and Foundation Trusts</i> (May 2013) published by the Care Quality Commission, Monitor, NHS Trust Development Authority, NHS England and the Department of Health and the experience from Professor Sir Bruce Keogh's <i>Review into the quality of care and treatment provided by 14 hospital trusts in England</i> which included, for example, an independent review that included the views of clinical and other experts.</p>	<p>Commission inspection identified that the levels of care were not of an adequate standard. The Care Quality Commission is also introducing a special measures process for primary care and adult social care providers that are rated "inadequate", to ensure they improve within no more than twelve months, or face losing their registration. In cases of serious breaches of the new fundamental standards, or of risk to people using services, the Care Quality Commission can also use its enforcement powers right away, including prosecution.</p>
123	<p>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 if they are to be successful commissioners.</p>	<p>Accepted.</p> <p>GPs, both in their roles as care providers and in clinical commissioning groups, should be continuously reviewing the quality of care provided by the acute hospital and specialised services they commission. NHS England continues to develop relevant guidance and tools for clinical commissioning groups to monitor the quality of service provision and support continuous improvement in quality.</p> <p>Clinical commissioning groups are under an important duty to assist and support NHS England in securing continuous improvement in the quality of primary medical services. They will need to do this working alongside the NHS England Area Teams, local Healthwatch and other parts of the system. NHS England and clinical commissioning groups are developing a Framework for Commissioning for Quality, through the NHS Commissioning Assembly, which will set out the steps that commissioners should take to assure themselves and their patients that the services that they are commissioning are safe, clinically effective and result in a positive experience for patients. This will be published in Autumn 2013.</p> <p>Clinical commissioning groups in a local area will be part of the new local Quality Surveillance Groups, where they should share information and intelligence with other parts of the local system. If they have concerns about whether providers are meeting the essential standards of quality and safety, they should raise these with the Care Quality Commission and with any other parts of the system with an interest through that Group. This should include concerns they have about providers from whom they do not commission services, such as primary care providers, but with whom they interact'</p> <p>There are other mechanisms through which GPs can report concerns about services. As health professionals, GPs are able to exercise their discretion when updating patient records, to incorporate comments on a patient's care, and patients themselves will be able to gain online access to their GP record by 2015. In addition, NHS providers should be publishing online aggregated feedback on the quality of care delivered by their organisation, and we would expect GPs to make themselves aware of this feedback and to use it to advice patients on their care. NHS England are undertaking further work to improve and increase the level of patient safety incident reporting to the National Reporting and Learning System by GPs through work with the Primary Care Patient Safety Expert Group and as part of the Strategic Framework for Commissioning Primary Care. Finally, any serious incidents that GPs identify should be reported to the NHS SI reporting system, the Strategic Executive Information System, as set out in the NHS England Serious Incident</p>	<p>NHS England has continued to develop relevant guidance and tools for clinical commissioning groups, to support them in monitoring the quality of service provision and in driving continuous improvement in quality. A framework for commissioning for quality, <i>Commissioning for Quality – Views from Commissioners</i> was published in July 2014.</p> <p>In <i>Transforming Primary Care</i> (April 2014), the Department of Health and NHS England set out how the Secretary of State for Health's vision for a vulnerable older people's plan and better integrated out of hospital care will be put into practice, including a named GP for all people aged 75 and over since June 2014. Since September 2014 GPs have also take the lead in developing a proactive and personalised programme of care and support for over 800,000 people with the most complex needs.</p> <p>By Spring 2015 every patient will be able to see their records, test results, book appointments and order repeat prescriptions online. They will also be able to communicate with their GP practice electronically. This will support a greater transparency for patients about their care and treatment and make it easier for patients to access details about their care and its outcome.</p>

		<p>Framework published in March 2013.</p> <p>The clinical commissioning groups authorisation process was built around six domains, and was developed by working with clinical commissioning groups, national primary care organisation and other stakeholders. Assessing clinical commissioning groups through these six domains provides assurance that clinical commissioning groups can safely discharge their statutory responsibilities for commissioning healthcare services. They are also intended to encourage clinical commissioning groups to be organisations that are clinically led and driven by clinical added value.</p> <p>One domain, 'Meaningful engagement with patients, carers and their communities' specifically looked at how clinical commissioning groups could show how they will ensure inclusion of patients, carers, public communities of interest and geography, health and wellbeing boards and local authorities. This included showing their mechanisms for gaining a broad range of views then analysing and acting on these. It should be evident how the views of individual patients are translated into commissioning decisions and how the voice of each practice population will be sought and acted on.</p> <p>One of NHS England's key functions is to develop the assurance process which identifies how well clinical commissioning groups are performing against their plans to improve services and deliver better outcomes for patients, as well as working together to assess how they can realise their full potential and provide support on that journey. Sitting alongside NHS England as fellow commissioners, clinical commissioning groups need to secure quality today and transform services for the future.</p> <p>And we will go even further in clarifying the role of the GP in coordinating patient care. On 5 July 2013, the Secretary of State for Health announced an intention that every vulnerable older person should will have a named clinician responsible for overseeing their care at all times when they are out of hospital, whether they are at home or in a care home. Through the work to develop a vulnerable older people's plan, the Department of Health is working with NHS England and others to look at how we can achieve better integrated, coordinated out of hospital care.</p> <p>To do this role well, clinicians both inside and outside of hospitals will have to work together to share information and provide a seamless, integrated pathway of care to patients. A part of the work to develop a Vulnerable Older People's Plan is about making sure that information can be shared between services and people providing care in a coordinated and timely way, including all clinicians and carers having access to the same information about patients regardless of setting.</p> <p>When the NHS has got this right for older people – those who need healthcare services the most and who often have complex health and care needs – this should become a much broader transformation in out of hospital care – one which will eventually help every NHS patient.</p>	
124	<p>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</p>	<p>Accepted in principle.</p> <p>Fundamental standards of care will be a key part of Care Quality Commission registration requirements and so commissioners will only contract with providers that are meeting these standards.</p> <p>Commissioners must have regard to any fundamental standard that relates to a service they commission, and they should apply it where they can. They can set</p>	<p>Revised provisions, particularly relating to commissioner's rights to suspend the provision of services, were published in December 2013 as part of the NHS Standard Contract for 2014–15. NHS England will continue to keep the provisions in the NHS Standard Contract under review.</p>

	<p>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.</p>	<p>safety and quality standards for all services they commission, through clear specification. The NHS Standard Contract allows for agreement at local level of the method of measuring compliance with such standards, and any appropriate sanctions.</p> <p>We have considered whether commissioners should consider incentivising compliance through redress for individual patients, which has been tested with providers and commissioners, and the overwhelming response was that this would not be practicable. Potential difficulties would be:</p> <ul style="list-style-type: none"> • a drain of funds from the local health community, where funds may be most needed; • the potential for perverse incentives to claim compensation; • duplication with existing rights for patients to be recompensed through litigation; and • methodological challenges in assessing the appropriate level of recompense. 	
125	<p>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.</p>	<p>Accepted.</p> <p>The NHS Standard Contract allows for agreement on a range of quality standards or development towards higher standards. Incentives should thus contribute to improved outcomes through improvement in the quality of health services for patients, their families and carers, and through reducing health inequalities. NHS England will be setting and incentivising enhanced standards through a 'pick-list' of evidence based indicators for improvement, against which it and clinical commissioning groups can set improvement trajectories and a number of non-mandated best practice service specifications to use with providers. NHS England will continue to make significant funding available (up to 2% of provider contract value) for commissioners to use in setting local improvement goals.</p>	<p>NHS England has set and incentivised enhanced standards for 2014/15 through a 'pick-list' of evidence based indicators for improvement. The Commissioning for Quality and Innovation scheme for 2014/15 provides a national framework through which organisations providing healthcare services under the NHS Standard Contract can earn incentive payments of up to 2.5% of their contract value by achieving agreed national and local goals for service quality improvement. NHS England will continue to keep the provisions in the NHS Standard Contract under review.</p> <p>The quality premium rewards Clinical Commissioning Groups for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.</p> <p>The quality premium paid to Clinical Commissioning Groups in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – will be based on six measures that cover a combination of national and local priorities. These are:</p> <ul style="list-style-type: none"> • reducing potential years of lives lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality (15 % of quality premium); • improving access to psychological therapies (15 % of quality premium); • reducing avoidable emergency admissions (25 % of quality premium); • addressing issues identified in the 2013/14 Friends and Family Test, supporting roll out of Friends and Family Test in 2014/15 and showing improvement in a locally selected patient experience indicator (15 % of quality premium); • improving the reporting of medication-related safety incidents based on a locally selected measure (15 % of quality premium); • a further local measure that should be based on local priorities such as those identified in joint health and wellbeing strategies (15 % of quality premium). <p>The quality premium will be further developed to confirm the combination of national and local priorities that will determine the amount to be paid to Clinical Commissioning Groups in 2016/17 to reflect the quality of health services commissioned in 2015/16. Details will be published alongside the NHS Standard Contract for 2015/16, and details of other incentives to improve quality.</p>
126	<p>The NHS Commissioning Board and local commissioners should develop and oversee a</p>	<p>Accepted.</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>

<p>code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups are formed, and guidance for commissioners on what they should expect to see in any organisational transitions among their providers.</p>	<p>NHS organisations have gained significant learning from the transition to the reformed NHS system in 2013. NHS England will continue to work with commissioners to build on this, so that information handed over in future transitions is comprehensive and candid.</p> <p>The handover process from Strategic Health Authorities and Primary Care Trusts to the reformed NHS system was developed with guidance on effective quality handover from the National Quality Board, to address the requirements of managing organisational transitions. This will be used as a template for future transitions.</p> <p>The key lessons on effective transition identified by the National Quality Board included:</p> <ul style="list-style-type: none">• the need for clarity of purpose with time for the system to understand and meet the requirements of a handover process;• documenting information is an important discipline, but the most valuable part of the process was the face-to-face conversations between individuals;• information should not only be handed over in order to reduce risk; the ambition for quality improvement should be handed over, so that services continue to improve for patients;• documents need to be easy to access and navigate by the recipient, so that it is apparent where the areas of risk are in terms of quality. Too much information is as unhelpful as too little;• the documents are for the benefit of recipients, and should tell them whatever they need to know in order to help them exercise their new accountabilities. They should not be confused with an attempt to record the achievements of the existing organisation;• triangulation of data (both hard and soft) did not always happen between all of the relevant bodies, such as the regulators, but when it did it was extremely helpful. We need to be much clearer about the requirements of our key stakeholders;• it is vital that patient experience data is captured as part of the quality assessment and to find ways of engaging with patient groups as part of the process of triangulation;• 'looking and seeing' should form part of the triangulation process wherever possible;• while data was generally strong and comprehensive on the acute sector, we need to extend and improve our inclusion of data on the quality of primary, secondary and tertiary care, social care, ambulance services, screening programmes, offender health, mental health and the independent and third sectors;• the responsibility for the handover should sit equally with both the receiver and the sender. i.e. if there are gaps in the documentation handed over, then it is the duty of the recipient to proactively seek to fill those gaps;• the requirement to take handover documents to the public sessions of boards helped the process to be taken seriously, and was in line with the proposed new Duty of Candour. On the whole the media treated this information responsibly;	
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		<ul style="list-style-type: none"> embedding documents is not good practice, as the information can be lost as links and websites close down. We need to use technology better to ensure that documents are kept 'live' and electronically available to those who need it, with better version control; some issues transcend individual organisations, and there may be a need for a small number of thematic handovers in order to maintain quality during transition. <p>NHS England will consider with clinical commissioning groups what further support and guidance might be required.</p>	
127	<p>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.</p>	<p>Accepted.</p> <p>The NHS Standard Contract, NHS England's assurance of clinical commissioning groups, and the development of commissioning support services, together provide a new infrastructure to ensure that commissioners have the capacity and capability to scrutinise providers' services.</p> <p>The NHS Standard Contract provides a clear framework through which commissioners can hold providers to account for service quality and safety, and NHS England will continue to develop this further for 2014–15.</p> <p>Commissioning comprises some activities for which the statutory commissioning body must retain ultimate responsibility, but there is also a range of other, key support functions which it may be more effective and efficient to be secured externally. These are known as 'commissioning support services'. Commissioning support services typically include:</p> <ul style="list-style-type: none"> Health Needs Assessment; business intelligence; support for redesign; communications and patient and public engagement; procurement and market management (agreeing contracts); provider management (monitoring contracts). <p>Provision of commissioning support services is currently dominated by 19 commissioning support units, created from Primary Care Trusts and hosted by NHS England and the NHS Business Services Authority until 2016.</p> <p>Work has already been done through NHS England's clinical commissioning groups assurance programme and through the development of commissioning support services to assure the quality of infrastructure and support within, and available to, commissioning organisations. NHS England will continue to develop this as an objective in its Commissioning Support Services Strategy.</p>	<p>The NHS Standard Contract continues to provide a clear framework through which commissioners can hold providers to account for quality and safety. Revised provisions, particularly relating to commissioner's rights to suspend the provision of services, were published in December 2013 as part of the NHS Standard Contract for 2014-15.</p> <p>NHS England has developed a new framework agreement for commissioning support services – the Lead Provider Framework – that from January 2015 will give clinical commissioning groups, NHS England and other customers a choice of supplier for some or all of their commissioning support needs, ranging from transactional back office support services to more bespoke services that support local and large scale transformational change projects. The Framework will be available to any organization, within or outside the NHS that wishes to procure some or all of its health and social care support services from a variety of accredited providers. It is anticipated that between £3bn and £5bn of services will be procured through it over the next four years. Use of the framework is optional for clinical commissioning groups.</p>
128	<p>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</p>	<p>Accepted.</p> <p>Commissioning support services have been developed to provide commissioners</p>	<p>NHS England is introducing a Lead Provider Framework agreement for commissioning support services to ensure that clinical commissioning groups and other commissioners have a choice of the best and most efficient</p>

	<p>procurement expertise. When groups are too small to acquire such support. they should collaborate with others to do so.</p>	<p>with the range of capacity and expertise required to commission effectively.</p> <p>Commissioning comprises some activities for which the statutory commissioning body must retain ultimate responsibility, but there is also a range of key support functions which the statutory body not only does not have to undertake itself, but for which it may be more effective and efficient to secure externally. These are known as ‘commissioning support services’. Commissioning support services typically include:</p> <ul style="list-style-type: none"> • Health Needs Assessment; • business intelligence; • support for redesign; • communications and public and patient engagement; • procurement and market management (agreeing contracts); • provider management (monitoring contracts). <p>Provision of commissioning support services is currently dominated by 19 commissioning support units, created from Primary Care Trusts and hosted by NHS England and the NHS Business Services Authority until 2016.</p> <p>NHS England will prioritise the further development of the expertise and resources required in its Commissioning Support Services Strategy, and in underpinning products such as quality standards, continuity of service, and procurement vehicles.</p>	<p>commissioning support suppliers. For further information on the Framework see recommendation 127</p>
129	<p>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.</p>	<p>Accepted.</p> <p>NHS England will support and assure clinical commissioning groups to develop indicators and measures of compliance with appropriate patient involvement. These will include, and build on, the fundamental standards of care that providers of care will be required to meet. NHS England and clinical commissioning groups are developing a <i>Framework for Commissioning for Quality</i> which will set out the steps that commissioners should take to assure themselves and their patients that the services that they are commissioning are safe, clinically effective, and result in a positive experience for patients</p>	<p>NHS England has continued to develop relevant guidance and tools for clinical commissioning groups, to support them in monitoring the quality of service provision and supporting continuous improvement in quality. A framework for commissioning for quality, <u><i>Commissioning for Quality – Views from Commissioners</i></u> was published in July 2014.</p>
130	<p>Commissioners – not providers – should decide what they want provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers and from elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail.</p>	<p>Accepted.</p> <p>We agree with the principle that it is for commissioners to determine what must be provided. Commissioners will increasingly commission for outcomes, in line with the NHS Outcomes Framework, leaving to providers some of the detail of how the service is delivered to achieve those outcomes.</p> <p>As part of the reformed commissioning system, there are a range of mechanisms for providers, and particularly their clinicians, to offer advice and proposals to commissioners. Strategic Clinical Networks, hosted by NHS England, bring together clinicians to drive change and improvements in the areas of cancer, coronary heart disease, mental health, and maternity and children’s services. In addition, Clinical Senates bring together clinicians from all sectors of healthcare, patients and other partners, to give advice to commissioners and providers in their area to help them make the best decisions about healthcare for the populations they represent.</p> <p>The reforms to the commissioning system will strengthen the ability of</p>	<p>NHS England has continued to develop relevant guidance and tools for clinical commissioning groups, to support them in monitoring the quality of service provision and supporting continuous improvement in quality. A framework for commissioning for quality, <u><i>Commissioning for Quality – Views from Commissioners</i></u> was published in July 2014</p>

		commissioners to secure the services they want for their population. NHS England and clinical commissioning groups are developing a Framework for Commissioning for Quality which will set out the steps that commissioners should take to assure themselves and their patients that the services are safe, clinically effective and result in a positive experience for patients.	
131	Commissioners need, wherever possible, to identify and make available alternative sources of provision. This may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with providers.	<p>Accepted.</p> <p>Commissioners should only decide on models of provision based on the needs and best interests of their patients, in accordance with best practice and with Monitor's <u>Guidance for commissioners in ensuring the continuity of health services</u>. In doing this, commissioners should prioritise those services for which alternative sources of provision should be made available.</p> <p>NHS England supports commissioning being undertaken collaboratively, where appropriate. NHS England has provided guidance on collaborative commissioning, to support commissioners who wish to collaborate with one another. It is currently reviewing with clinical commissioning groups whether additional guidance and support would be helpful for 2014–15.</p>	<p>NHS England is supporting commissioners to explore new models of commissioning giving patients, local communities and local clinicians greater opportunities to influence how services are delivered. There will be three key changes to the commissioning system for 2015/16, described below.</p> <p>In May 2014, NHS England announced plans to work with clinical commissioning groups on the development of new models for the co-commissioning of primary care. 196 clinical commissioning groups submitted an expression of interest. Further guidance on co-commissioning has also been produced <u>Next steps towards primary care co-commissioning</u>. This guidance includes detailed overview of the different co-commissioning models and next steps towards implementation. The first delegated co-commissioning arrangements and joint commissioning arrangements involving a pooled budget are planned to be implemented from 1 April 2015.</p> <p>NHS England has asked a taskforce to analyse current specialised commissioning arrangements to bring about urgent improvements in the way services are commissioned. This move was instigated to address a number of challenges causing significant pressures across the system, gaining financial control but also ensuring that the services delivered to patients across England are planned and delivered safely and efficiently. The outcome is reflected in NHS England's planning guidance for 2015/16.</p> <p>In July 2014 NHS England announced plans to pool funding for key groups across local authorities, clinical commissioning groups and specialised commissioning from April 2015. The aims of this approach, to be known as Integrated Personal Commissioning, will be to test new commissioning and funding models and to explore how individuals can have more control over how the funding is used through personalised care and support planning. NHS England also aims to allow people to commission their own care and support through Personal Health Budgets. From October 2014, those in receipt of NHS Continuing Healthcare have the right to a Personal Health Budget, which will allow care and support to be organised that meets their needs. The NHS Mandate sets an ambitious objective that this should also include people with a long-term condition.</p>
132	<p>Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period:</p> <ul style="list-style-type: none"> Such monitoring may include requiring quality information generated by the provider. Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of 	<p>Accepted.</p> <p>Commissioning support services exist to provide this resource and expertise. Commissioning support services typically include:</p> <ul style="list-style-type: none"> Health Needs Assessment; business intelligence; support for redesign; communications and public and patient engagement; procurement and market management (agreeing contracts); provider management (monitoring contracts). 	<p>NHS England is introducing a Lead Provider Framework agreement for commissioning support services to ensure that clinical commissioning groups and other commissioners have a choice of the best and most efficient commissioning support suppliers. For further information on the Framework see recommendation 127.</p> <p>NHS England has continued to develop relevant guidance and tools for clinical commissioning groups, to support them in monitoring the quality of service provision and in driving continuous improvement in quality. A framework for commissioning for quality, <u>Commissioning for Quality – Views from Commissioners</u> was published in July 2014</p>

	<p>groups of cases.</p> <ul style="list-style-type: none"> The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation. Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the 	<p>These functions cover the key elements of this recommendation regarding monitoring quality information, including compliance with fundamental and enhanced standards, and undertaking audits.</p> <p>NHS England will include this effective contract management and monitoring as an objective in its Commissioning Support Services Strategy and underpinning products, such as quality standards, continuity of service, and procurement vehicles.</p> <p>NHS England and clinical commissioning groups are developing a Framework for Commissioning for Quality which will set out the steps that commissioners should take to assure themselves and their patients that the services that they are commissioning are safe, clinically effective and result in a positive experience for patients.</p>	
133	<p>Commissioners should be entitled to intervene in the management of an individual complaint on behalf of a patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.</p>	<p>Accepted in principle.</p> <p>While we accept the spirit of this recommendation, we are concerned that it risks creating uncertainty over roles and responsibilities in the management of complaints. Clarity and consistency are critical for the patient.</p> <p>The NHS complaints process is based upon the premise that complaints are best dealt with by the local organisation. If the complainant remains dissatisfied, they are able to seek an independent review through the Health Service Ombudsman.</p> <p>We accept that in the cases of complaints of a serious nature, that may indicate a possible failure in care or a continued risk to patient safety, commissioners will want to be aware and take action where they believe a provider is in breach of their contract with regard to patient safety and service quality. The NHS standard contract requires providers to ‘implement Lessons Learned from complaints and demonstrate at Review Meetings the extent to which Service improvements have been made as a result’ – these review meetings take place between the provider and the commissioner. However, one of the lessons of the Mid Staffordshire Inquiry has been that this information needs to be meaningful – just noting the numbers of complaints received by an organisation is not effective. For 2014–15, NHS England are considering broadening the requirement on Lessons Learned to cover a wider spectrum of information, such as complaints, incidents and feedback from service users and staff, and the extent to which service improvements have been made as a result.</p> <p>The Department of Health will ensure that each quarter every hospital publishes information on the complaints it has received. This will include:</p> <ul style="list-style-type: none"> the number of complaints received, as a percentage of patient interventions in that period; the number of complaints the hospital has been informed have subsequently been referred to the Ombudsman; and lessons learned and improvements made as a result of complaints. <p>The Department of Health will work with NHS England and other key partners to determine the most effective mechanism through which to achieve these outcomes.</p> <p>The standard contract also requires the Provider to provide a complaints monitoring report. For 2014–15 NHS England are considering clarifying the expected content of the complaints report, to include meaningful information on complaints such as</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>

		<p>analysis of key themes in the content of complaints as well as the number of complaints received for each theme.</p> <p>The NHS Standard Contract already provides commissioners with powers to intervene in certain circumstances, for example to require remedial action, to impose financial sanctions, to suspend services or to terminate a contract. However, we are examining whether these provisions should be strengthened for 2014–15, with a view to making more specific provision for commissioner intervention, to suspend a service or an element of it, where there are reasonable grounds for material concern about patient safety or outcomes.</p> <p>However, enabling commissioning bodies to intervene in the management of an individual complaint would undermine the fundamental principle that local organisations themselves are, in the first instance, responsible for seeking to resolve a complaint. A commissioner could intervene if it considers an organisation's general handling of complaints cases needs to be improved – but their intervention would not be about the specifics of an individual case.</p> <p>The current complaints arrangements (laid out in regulations) are based on a 2-stage model. The first stage is local resolution. At this local level, a complaint about service provision may be made to <i>either</i> the service provider <i>or</i> to the body commissioning the service (but not both). If the person making the complaint is not satisfied with the outcome at this local resolution stage, they have the right to ask the Health Service Ombudsman to investigate the case. The Ombudsman is independent of Government and the NHS, accountable to Parliament.</p>	
134	<p>Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.</p>	<p>Accepted.</p> <p>The <i>Health and Social Care Act 2012</i> gave responsibility for commissioning NHS complaints advocacy to individual Local Authorities; the Local Authorities took responsibility from April 2013. Local Authorities are best able to determine the needs of their local populations.</p> <p>The review of the handling of NHS complaints has recommended that 'the independent NHS Complaints Advocacy Service should be re-branded, better resourced and publicised. It should also be developed to embrace greater independence and support to those who complain. Funding should be protected and the service attached to local Healthwatch organisations.'</p> <p>The Department of Health recognises that the current arrangements for the commissioning of complaints advocacy services are new. The Department of Health will begin an evaluation of the current arrangements for commissioning NHS advocacy services in 2014.</p>	<p>It is recognised that complainants may need assistance to make a complaint and Local Authorities commission advocacy services to provide this support. However, in order to give the public a better understanding of what to expect when receiving this support, Healthwatch England has developed a set of national standards for complaints advocacy services, generated from workshops and interviews with people who use advocacy services.</p>
135	<p>Commissioners should be accountable to their public for the scope and quality of services they commission. Acting on behalf of the public requires their full involvement and engagement:</p> <ul style="list-style-type: none"> • There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners. 	<p>Accepted in part.</p> <p>Provisions for a new commissioning system in the Health and Social Care Act 2012 address most of the elements of this recommendation. For example, provisions cover the new role of lay members on Clinical Commissioning Group governing bodies, the duty on public involvement and consultation on both NHS England and clinical commissioning groups, and the key role of local Healthwatch in giving people a powerful voice locally in improving and shaping health services.</p> <p>A range of mechanisms is now available for involving the public in commissioning</p>	<p>By December 2013, 80% of clinical commissioning groups were commissioning support for patients' participation and decisions in relation to their own care or had a plan to do so.</p> <p>A Citizens Assembly was launched in March 2014, with the first Excellence in Participation Awards held alongside this to celebrate excellence and innovation in patient and public participation.</p> <p>A task and finish group has been established to help develop guidance for commissioners and providers on the definition, principles and processes of personalised care planning; this guidance was published in January 2015.</p> <p>A number of commissioning support units have been appointed to provide</p>

	<ul style="list-style-type: none"> • There should be lay members of the commissioners' board. • Commissioners should create and consult with patient forums and local representative groups. Individual members of the public (whether or not members) must have access to a consultative process so their views can be taken into account. • There should be regular surveys of patients and the public more generally. • Decision-making processes should be transparent: decision-making bodies should hold public meetings. <p>Commissioners need to create and maintain a recognisable identity which becomes a familiar point of reference for the community.</p>	<p>decisions without requiring the development of new 'membership' models. In September 2013 NHS England issued <i>Transforming Participation In Health And Care</i>, statutory guidance for clinical commissioning groups on involving patients in planning services and in their own care. By December 2013, 80% of clinical commissioning groups will be commissioning support for patients' participation and decisions in relation to their own care or will have a plan to do so. This will include information and support for self-management, personalised care planning and shared decision-making.</p> <p>There are a number of regular national and local patient and public surveys. These include the annual national GP patient survey, run for NHS England by Ipsos MORI, and a national programme of patient surveys run for the Care Quality Commission by Picker Institute Europe. In addition, since April 2013 all providers of NHS funded care have been required to offer inpatients and users of accident and emergency services the opportunity to provide feedback through the NHS friends and family test. The first set of data for the Accident and Emergency friends and family test, covering April, May and June was published on 30 July 2013. A second set of this data was published on 30 August and a third on 3 October. 793,448 responses have been received to date. The current response rate is 17.1%.</p> <p>The friends and family test allows hospital trusts to gain real time feedback on their services down to individual ward level, and increases the transparency of NHS data to drive up choice and quality. The real strength of friends and family test lies in the follow-up questions that can be attached to the initial question, and a rich source of patient views can be used locally to highlight and address concerns much more rapidly than with more traditional survey methods.</p> <p>It is our intention that by March 2015, all NHS service users will be given the opportunity to provide feedback through the friends and family test. Maternity services started using the Test from 1 October 2013, with the first set of results to be published after the first quarter, at the end of January 2014. Work is currently underway to develop guidance for the introduction of the test to all other NHS settings. Guidance for staff to support the introduction of the friends and family test from April 2014 is on course to be published by the end of December 2013.</p> <p>NHS England is developing plans to establish in 2014 a Citizens Assembly – pioneering a new approach to ensuring citizen voice is able to hold it to account. NHS England has also established a 'Voices in Governance' model in Specialised Commissioning, to ensure that the patient and public voice is at the heart of commissioning processes.</p> <p>NHS England and clinical commissioning groups are developing, through the NHS Commissioning Assembly, a <i>Framework for Commissioning for Quality</i> which will be published in Autumn 2013. It will set out the steps that commissioners should take to assure themselves and their patients that the services that they are commissioning are safe, clinically effective and result in a positive experience for patients.</p> <p>Clinical Commissioning Groups are required to take a number of steps to ensure transparency in their decision making processes. The constitution of the Clinical Commissioning Group must specify the arrangements made for securing that there is transparency about the decisions of the group and the manner in which they are made. The governing body must also publish papers considered at its meetings (except where it would not be in the public interest to do so).</p>	<p>support to clinical commissioning groups in engaging with patients and the public. Ongoing support is also being provided to NHS England commissioners in specialised commissioning to ensure the participation of patients and the public.</p> <p>The Friends and Family test became available in GP practices on 01 December 2014 and then expanded to mental health services and community services on 01 January 2015. Other services will offer the friends and family test from April 2015 such as NHS dental practices, ambulance services, patient transport services, acute hospitals outpatients and day cases. The aim is for the Friends and Family test to cover all NHS services by the end of 2015. <u>Guidance</u> for staff on the Friends and Family test was published in February 2014.</p>
136	Commissioners need to be recognisable public bodies, visibly acting on behalf of the	Accepted.	No further update is required. Please see response to the recommendation in Hard Truths

	<p>public they serve and with a sufficient infrastructure of technical support. Effective local commissioning can only work with effective local monitoring, and that cannot be done without knowledgeable and skilled local personnel engaging with an informed public.</p>	<p>NHS England will support and assure clinical commissioning groups to be recognisable, visible local bodies.</p> <p><u><i>The National Health Service (Clinical Commissioning Groups) Regulations 2012</i></u> already require that clinical commissioning groups' names reflect their local community, so that they are recognisable and have a clear link to their locality.</p> <p>Clinical Commissioning Groups demonstrate their accountability to their members, local people, stakeholders and NHS England in a number of ways, including by:</p> <ol style="list-style-type: none"> a) publishing their constitution; b) appointing independent lay members and non GP clinicians to the governing body; c) holding meetings of the governing body in public; d) publishing annually a commissioning plan; e) complying with local authority health overview and scrutiny requirements; f) meeting annually in public to publish and present its annual report (which must be published); g) producing annual accounts in respect of each financial year which must be externally audited; h) having a published and clear complaints process; i) complying with the Freedom of Information Act 2000; j) providing information to NHS England as required. <p>Commissioning support services have been developed to provide the infrastructure of technical support that clinical commissioning groups require. Commissioning support services typically include:</p> <ul style="list-style-type: none"> • Health Needs Assessment; • business intelligence; • support for redesign; • communications and public and patient engagement; • procurement and market management (agreeing contracts); • provider management (monitoring contracts). <p>These services underpin the effective local monitoring required to support clinical commissioning groups be effective, visible and well engaged local commissioners.</p>	
137	Commissioners should have powers of intervention where substandard or unsafe	Not accepted, however we agree the underlying of this recommendation to avoid	Revised provisions relating to commissioners' rights to suspend the provision of services were published in December 2013 as part of the NHS Standard

<p>services are being provided, including the substitution of staff or other measures necessary to protect the patients from the risk of harm. In the provision of commissioned services, such powers should be aligned with similar powers of the regulators so that both commissioners and regulators can act jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop the provision of a service.</p>	<p>inaction on the part of regulators and commissioners because of a lack of clarity about their respective roles.</p> <p>The respective roles of commissioners and regulators in their relationships with providers are different and must be distinct. Commissioners arrange the provision of high quality services to meet the needs of the people they are responsible for, and can take direct action with providers when they are not delivering to contractual specifications. The regulators are charged to ensure that providers meet set standards, and to give regulators and commissioners equivalent powers of intervention would blur the distinction of these roles and risk causing confusion in the system, resulting in inaction because of assumptions that another body is intervening to address a problem.</p> <p>The NHS Standard Contract enables commissioners to intervene where substandard or unsafe services are being provided. In extremis, under the terms of the standard contract, the commissioners can suspend services, or elements of them, and terminate contracts. Enforcement action, which may entail the substitution of staff, is properly the role of the regulators: the Care Quality Commission will retain all of its existing enforcement powers and will not be constrained from taking swift and decisive action if patients are at immediate risk of harm. Where there is no immediate risk of harm to patients but concerns exist, the Care Quality Commission will normally look to Monitor or the NHS Trust Development Authority to exercise their powers to take enforcement action at NHS Trusts and Foundation Trusts. In determining the potential benefits of an intervention, Monitor will consider whether the best outcome for healthcare service users can be achieved by acting themselves or acting together with another organisation, or whether another organisation such as the Care Quality Commission, NHS Trust Development Authority or NHS England has tools that could tackle an issue more effectively, or is already taking steps that are likely to address the potential harm. However any enforcement activity by the Care Quality Commission does not preclude Monitor from exercising its enforcement powers if relevant to do so, and vice versa.</p> <p>Where Health Education England has concerns about the quality of clinical placements or training being provided by a provider it will take action to remedy this. If necessary, Health Education England will withdraw clinical placements or training programmes from a provider until they are able to demonstrate the required level of improvement and ensure a safe training environment for patients, students and trainees</p> <p>In <u>Patients First and Foremost</u> the Department of Health agreed that, ‘...regulators and commissioners should ensure that they have a shared picture of provider performance...’ NHS England, clinical commissioning groups, the Care Quality Commission, Monitor, the NHS Trust Development Authority, Health Education England and the professional regulators (General Medical Council and Nursing and Midwifery Council) can align their powers of intervention by means of Quality Surveillance Groups. NHS England has rolled Quality Surveillance Groups out across England in each area and region. These are all actively engaged in sharing information and intelligence between commissioners, regulators and other organisations on the quality of care being delivered. If commissioners have concerns about whether providers are meeting the essential standards of quality and safety, Quality Surveillance Groups are one of the mechanisms through which they can raise their concerns with the Care Quality Commission, Monitor and with any other parts of the system with an interest. This includes concerns individual commissioners have about providers from whom they do not commission services, but with whom they interact (for example, clinical commissioning groups and primary care providers). The National Quality Board is currently conducting a review of how the Quality Surveillance Group network is operating, and what support it needs to be as effective as possible. It will publish revised guidance and support materials by the end of 2013 to support all Quality Surveillance Groups in reaching</p>	<p>Contract for 2014-15.</p> <p>In March 2014 the National Quality Board published new <u>guidance</u> to support and share good practice amongst Quality Surveillance Groups as they develop. A Quality Dashboard supports Quality Surveillance Groups in analysing data on quality. The indicators within it have been aligned to those used by the Care Quality Commission in their Intelligent Monitoring System.</p> <p>NHS England, Monitor, the Care Quality Commission and the NHS Trust Development Agency plan to develop a common dataset for quality for use by commissioners and regulators as soon as possible.</p>
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		their full potential.	
138	Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found they are at risk from substandard or unsafe services.	<p>Accepted.</p> <p>Commissioners must develop plans to ensure that safe and effective services can continue to be provided in the event of a provider failure.</p> <p>NHS England is supporting commissioners to develop plans for responding to a serious provider failure, in line with Monitor's guidance and rules on service continuity.</p> <p>The Department of Health, the Care Quality Commission, NHS England, Monitor and the NHS Trust Development Authority are working together to develop a single failure regime (outlined in the response to recommendation 19), which will ensure that financial and quality failures are handled in a consistent way and can be enacted where risks to quality and patient safety are identified. As part of that regime, the Care Quality Commission, NHS Trust Development Authority and Monitor will work together, with the trust and its commissioners, to ensure that where concerns are raised, the trust acts swiftly to resolve them. This will provide external support and assurance that appropriate action has been taken or may indicate that further action is needed.</p>	With support from NHS England, many commissioners have developed plans for responding to a serious provider failure, in line with Monitor's service continuity guidance. All clinical commissioning groups will be required to have these plans in place by 2015/16.
139	The first responsibility for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring 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.	<p>Accepted.</p> <p>Registration by the Care Quality Commission and Monitor's licencing of providers gives an assurance to commissioners that a provider meets fundamental standards of care. The NHS Standard Contract provides a framework for commissioners to receive on-going assurance on compliance with standards, through its routine performance management processes.</p>	The Care Quality Commission's new-style inspections involve larger teams and more in depth inspections. These inspections against the new fundamental standards of care, provide greater clarity on a hospital's performance and show where improvements are required, if necessary.
140	Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including information about its judgement as to the safety of patients of the healthcare provider.	<p>Accepted.</p> <p>The processes associated with Quality Surveillance Groups and risk summits provide the framework for this. NHS England is reviewing the effectiveness of these arrangements. Strong bilateral relationships should also be in place between the commissioners, regulators and NHS England's area teams</p> <p>Key organisations and regulators, including the NHS Trust Development Authority, Monitor, the Care Quality Commission and NHS England, have published agreements that set out the ways in which they are working together and sharing information outside of Quality Surveillance Group meetings so that there is a single common assessment of the quality and sustainability of any given provider.</p>	A review of the Quality Surveillance Group model has been undertaken by all of the organisations represented on the National Quality Board and on Quality Surveillance Groups, to understand how they are operating and identify where they could be supported to be more effective. As a result of this review the National Quality Board published a second edition of the 'How To' guide <i>How to make your Quality Surveillance Group Effective</i> in March 2014.
141	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.	<p>Accepted in principle.</p> <p>Commissioners and regulators should have clear and distinct roles in ensuring the safety of people who use services and should act swiftly where patients are at risk. Local and regional Quality Surveillance Groups actively share information and intelligence, including qualitative intelligence, including issues and cases of media and public interest, between commissioners, regulators and other organisations on the quality of care being delivered. This provides a mechanism to share and discuss safety concerns between commissioners and regulators. In addition to the coordinated process outlined in recommendation 19 as part of the single</p>	No further update is required. Please see response to the recommendation in Hard Truths

		<p>failure regime, the NHS Standard Contract enables commissioners to intervene where substandard or unsafe services are being provided. This includes the ability to suspend services, or elements of them, and terminate contracts. See recommendation 137 for further details.</p> <p>In addition, the Care Quality Commission will retain its ability to stop a service from providing care if it is putting people at immediate risk of harm as outlined by the Health and Social Care Act 2008. The Act states that where the Care Quality Commission has 'reasonable cause' to believe that unless it acts people may be exposed to the risk of harm, it may impose or vary a condition of a provider's registration or suspend it from the point written notice is given as part of an urgent response.</p> <p>In addition, subject to the passage of regulations, during 2014 the Care Quality Commission will also have new powers to prosecute a provider for failing to provide fundamental levels of care, without having to issue a formal warning first. See recommendation 28 for further details.</p>	
142	<p>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.</p>	<p>Accepted.</p> <p>The reformed NHS system includes a number of different lines of accountability, so it is crucial that there is no ambiguity or confusion about these accountabilities or about the information flows which inform them.</p> <p>Providers are accountable to their commissioners for the quality of services they deliver. The NHS Standard Contract provides for clarity on information flows between provider and commissioner.</p> <p>In primary care, the introduction of the General Practice Extraction Service and Calculating Quality Reporting Service ensures that clear and accurate performance management information is provided within services commissioned from GP contractors.</p> <p>NHS Trusts are also accountable to the NHS Trust Development Authority for their overall performance, including for providing high quality services. The accountability arrangements for NHS Trusts are set out in <i>Delivering High Quality Care for Patients: The Accountability Framework for NHS Trusts</i>. The <i>Accountability Framework</i> is aligned with the standards set by Monitor and the Care Quality Commission, and the Trust Development Authority continues to work with its partners to ensure that it reflects any relevant changes, such as the Care Quality Commission's new regime for the monitoring, inspection and rating of healthcare providers.</p> <p>NHS England and the NHS Trust Development Authority have agreed protocols to ensure that there is no uncertainty or duplication in processes for intervening in local health communities where there are concerns about quality or safety.</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>
143	<p>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.</p>	<p>Accepted.</p> <p>A range of metrics are collected and published across the health sector that relate directly to the quality of patient care. This includes data on infection control (Public Health England), safety incidents (NHS England), Summary Hospital-level Mortality Indicator (Health and Social Care Information Centre) and, patients' feedback reported on NHS Choices among other sites.</p>	<p>As of June 2014, NHS Choices is publishing more in-depth and detailed information about the safety of hospitals that allows for scrutiny of services and identification of variations between similar services. The new safety section includes an NHS Choices rating of hospitals against six safety indicators and information on safe nurse staffing levels. From April 2014, NHS England began publishing data monthly about any trusts who failed to declare compliance with stage one, two, or three National Patient Safety Agency alerts by their set due date, and since June 2014 patients and the public can view this information as</p>

The Health and Social Care Information Centre publishes performance information and statistics, using transparent calculations, so that they can be used across the health and care system to review performance and identify concerns. The Health and Social Care Information Centre's [Indicator Portal](#) for national quality indicators extend this service.

In addition, from November 2013 NHS England will begin to extend NHS Choices so that it will bring together the most reliable and relevant data from national web services and act as a 'front door' to the best information on health and social care on the internet.

Details of how this information will be used by Care Quality Commission as part of its new inspection regime is outlined in recommendation 20.

NHS England and Care Quality Commission are committed to working together to develop a shared and agreed approach to measuring safety in the NHS, both for regulatory and improvement purposes. NHS England is currently in discussion with Care Quality Commission about which patient safety measures, including incident reporting, are best suited for use in their surveillance model, and how NHS England can contribute to their interpretation. This includes providing Care Quality Commission with access to the relevant patient safety expertise to inform how they use patient safety data in their surveillance and inspection processes, including what 'good' looks like and what data should be considered a cause for concern. Care Quality Commission will be setting out its new surveillance and inspection model and NHS England will be setting out its safety measurement framework in due course.

part of the set of key indicators on the NHS Choices safety website. In addition, from June 2014, two 'harms' that are measured by the NHS Safety Thermometer can now be viewed on the NHS Choices website.

NHS England and the Care Quality Commission have worked jointly to ensure a shared view of patient safety data (and what it means) is developed and that this is reflected in the new Care Quality Commission's surveillance model for acute and specialist NHS Trusts. The Care Quality Commission now has free and unfettered access to all incident reporting information collected by the National Reporting and Learning System and through the Strategic Executive Information System. The Care Quality Commission and NHS England's Patient Safety Domain regularly meet to share information, review and co-develop initiatives to improve patient safety. For example, NHS England and the Care Quality Commission have co-developed the indicators that are used in the Care Quality Commission's Intelligent Monitoring system. In March and July 2014, the Care Quality Commission also updated its [surveillance model](#) for acute and specialist NHS trusts.

The Care Quality Commission has put in place a system of Intelligent Monitoring to help decide when, where and what to inspect. This draws information and data from a range of sources to identify providers and services where there may be a greater risk of providing poor care. The evidence from the Intelligent Monitoring system is used to prioritise which providers will be inspected and the lines of enquiry during an investigation. The system triggers a response, for example, where there are a statistically significant number of severe harm incidents or avoidable deaths at a provider. "Never events" trigger an automated elevated risk in Intelligent Monitoring which inspectors follow up individually. The data it looks at includes information from:

- staff
- patient surveys
- mortality rates
- hospital performance information such as waiting times and infection rates

In October 2013 the Care Quality Commission began a pilot of its Intelligent Monitoring programme for acute and specialist NHS trusts. The pilot looked at more than 150 different sets of data (indicators), which related to the five key questions the Care Quality Commission asks of all services – are they safe, effective, caring, responsive, and well-led? Using this data, the Care Quality Commission grouped all acute NHS trusts into six priority bands for inspection. In March and July 2014, the Care Quality Commission updated its [surveillance model for acute and specialist NHS trusts](#).

In November 2014, the Care Quality Commission published Mental Health Intelligent Monitoring reports, which display the results of its analysis of Tier 1 indicators for all Mental Health NHS trusts. Each trust will receive an individual report and banding, similar to those for acute hospitals. The bandings ranges from one to four.

In November 2014 the Care Quality Commission published its first round of Intelligent Monitoring for GPs. Draft Intelligent Monitoring models for the Adult Social Care sector have been in place since October 2014, with separate sets of indicators for residential, community and hospice services.

The Care Quality Commission has always used important information in statutory notifications as an indicator of quality and safety in the adult social care sector, alongside other information about safeguarding alerts and information provided by others such as people who use services, staff and the public. The Care

			<p>Quality Commission does not have a lot of quantitative data consistently collected across the sector but it is taking steps to improve this. With a new, more thorough model the Care Quality Commission intends to use all the available information to check whether there is a risk that services do not provide either safe or quality care.</p> <p>The Care Quality Commission is currently developing the set of indicators for adult social care services. There are limitations in the coverage of national datasets, but the Care Quality Commission will start by making better use of the indicators it is developing, and then determine how it will improve this over time. The Care Quality Commission will be carrying out additional testing and engagement to determine the most useful indicators to inform its work.</p>
144	<p>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.</p>	<p>Accepted.</p> <p><i>The NHS Outcomes Framework 2013–14</i> (Department of Health, November 2012) contains a range of indicators that provide a balanced coverage of NHS activity that, taken together, provide a national overview of how well the NHS is performing. They provide the accountability mechanism between the Secretary of State for Health and NHS England for the effective spending of public money. The indicators are set out in five domains that cover the preventing of premature mortality; enhancing quality of life for people with long term conditions; helping people recover from episodes of ill health; ensuring the people have a positive experience of care; and treating people in safe environments and protecting them from avoidable harm.</p> <p>In addition to this, NHS England also publishes a range of data that supports improvement. In June 2013, NHS England published the first two specialities level data, cardiac surgery and vascular, and announced the publication schedule for a further eight specialties. All specialties have since been published.</p> <p>NHS England will widen this programme to include other specialties over time and the data published will, initially, be refreshed annually. This data will continue to be published as part of NHS Choices website.</p>	<p>The Clinical Commissioning Group <u>Outcomes Indicator Set</u> provides clear, comparative information for Clinical Commissioning Groups, Health and Wellbeing Boards, local authorities and patients and the public about the quality of health services commissioned by Clinical Commissioning Groups and the associated health outcomes. They are useful for Clinical Commissioning Groups and Health and Wellbeing Boards in identifying local priorities for quality improvement and to demonstrate progress that local health systems are making on outcomes. The measures are developed from NHS Outcomes Framework indicators that can be measured at Clinical Commissioning Group level together with additional indicators developed by the National Institute for Health and Care Excellence and the Health and Social Care Information Centre. Additional measures are added annually</p> <p>NHS England plans to publish consultant-level outcomes data from all appropriate NHS funded national clinical audits before 2020. The Consultant Outcomes Publication began with ten national clinical audits in June 2013. Consultant data for neurosurgery and upper gastro-intestinal has also now been published. NHS England will improve the way in which data is published and has supported the development of patient-friendly guidance which has been issued to professional societies. This outlines the indicators that must be included in consultant level reporting such as patient involvement in publication and the linking of results for the department to an individual's work at the trusts they practice in.</p>
145	<p>There should be a consistent basic structure for Local Healthwatch throughout the country, in accordance with the principles set out in <i>Chapter 6: Patient and public local involvement and scrutiny</i>.</p>	<p>Not accepted, however we share the underlying intention behind this recommendation to ensure consistency of outcomes for local communities with each local Healthwatch organisation providing a strong voice for their local population and helping to shape an effective local health and care system.</p> <p>We believe that local Healthwatch organisations should be set up in a way that best meets the needs and reflects the circumstances of their local communities; taking a top-down approach and imposing a fixed structure would undermine the need for flexibility.</p> <p>We believe that consistency of outcomes – with each local Healthwatch organisation providing a strong voice for the local population and helping to shape an effective local health and care system – is more important than consistency of form. As every local authority has now commissioned its Healthwatch provider, we also believe that retrospectively imposing a consistent structure at this stage would divert effort and resources from the important work that local Healthwatch organisations should be doing in their role as local consumer champions.</p> <p>We do, however, fully recognise the concerns about previous arrangements for patient and public involvement in Staffordshire, and the disproportionate – and ultimately damaging – focus on governance and organisational matters at the expense of ensuring the local community's concerns were heard and acted on.</p>	<p>Local Healthwatch have been publishing their annual reports for the first year of operation (2013/14), giving examples of the impact that they are having and how they are giving voice to local communities.</p> <p>Healthwatch England is continuing to provide support to local Healthwatch organisations to enable continuous improvement and sharing of good practice. The Department has continued to provide additional funding to Healthwatch England to boost its capacity to provide targeted support to specific local Healthwatch where needed. Healthwatch England is also enabling a focus on outcomes by developing guidance on what a good local Healthwatch looks like.</p> <p>Local authorities, as commissioners of local Healthwatch, have a critical role in ensuring that their provider is delivering effectively and meeting the needs of the local population. The Department has continued to provide funding to the Local Government Association to support commissioners of local Healthwatch during 2014/15. The Local Government Association's work programme is providing important support to local Healthwatch around fulfilling their role as members of health and wellbeing boards.</p> <p>The Department has also commissioned the King's Fund to review the impact of local Healthwatch and to identify the factors which contribute to a high-performing local Healthwatch. This is expected to report in spring 2015.</p>

		<p>As part of the new arrangements, one of the core roles of Healthwatch England at the national level is to provide support and leadership to local Healthwatch organisations. This year, as local Healthwatch organisations have been establishing themselves, Healthwatch England and the Local Government Association have provided important support to help them put in place clear governance arrangements that will enable them to focus on effective delivery of their local priorities.</p> <p>It is vital that local Healthwatch organisations continue to be supported and that any early signs that they are struggling to fulfil their role are identified and addressed. Local authorities are responsible for commissioning and performance managing their local Healthwatch provider. Alongside this, Healthwatch England has a crucial role in building capability across the network, and it will ensure that best practice is shared and there are clear standards in place for what a good local Healthwatch should be achieving. We will also work with Healthwatch England to ensure that they can develop and provide targeted support for local Healthwatch organisations that may need it.</p>	
146	<p>Local authorities should be required to pass over the centrally provide funds allocated to its Local Healthwatch, while requiring the latter to account 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.</p>	<p>Accepted in part.</p> <p>We do not accept that local authorities should be required to pass over centrally-provided funds. We believe that local authorities are best-placed to make decisions about funding services that meet the needs of their local communities – including local Healthwatch. We expect local Healthwatch organisations to have sufficient funding to deliver against their local priorities, but we do not believe it is for the Government to dictate what this level should be.</p> <p>As the Healthwatch network is new, it is not possible at this stage to specify the level of funding that is required to deliver an effective local Healthwatch function. But we do believe it is important that there is <i>transparency</i> about funding for local Healthwatch, and that this principle of transparency is embedded at the outset. We will therefore require each local Healthwatch to set out the amount of funding it receives in its annual report. Healthwatch England will also publish in December the amount of funding each local Healthwatch has received, and we are working with Healthwatch England to see what further steps can be taken to enable transparency.</p> <p>We agree that local Healthwatch should account to its local authority, as commissioner of Healthwatch, for its use of funding provided and it is the responsibility of local authorities to ensure that appropriate arrangements are in place.</p> <p>We agree that there is a balance to strike between respect for the independence of local Healthwatch organisations and the need to ensure that they are functioning effectively. Local authorities are responsible for holding their local Healthwatch provider to account. Healthwatch England already has the power to alert local authorities to concerns it may have around the performance of a local Healthwatch provider. In addition, as part of its own role in supporting local Healthwatch it has put in place measures to ensure that it has a robust overview of how the network is performing. We will work with Healthwatch England to ensure that, if needed, providers who may be struggling get the right support at the right time.</p>	<p>Healthwatch England has published information on local authority spend on local Healthwatch for 2013/14 and 2014/15. The Department is working with Healthwatch England to ensure ongoing transparency around funding for local Healthwatch.</p> <p>Local Healthwatch are also required to include in their annual reports, which are now published every summer, the funding that they have received from their commissioning local authority.</p>
147	<p>Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing</p>	<p>Accepted.</p> <p>The Department of Health has worked with partners to develop guidance that</p>	<p>In June 2014, the Department issued <u>guidance</u> to local authorities on how to scrutinise local health systems. The guidance supports local government, the NHS and other local partners to understand and develop their roles in relation</p>

	Boards, and local government scrutiny committees.	<p>will support effective scrutiny by local government of the commissioning and delivery of local services, helping to ensure they are effective and safe.</p> <p>The guidance is aimed at local authorities, Health and Wellbeing Boards, NHS commissioners and providers, and local Healthwatch. The guidance underlines the importance of all partners in the system understanding their own and each other's roles and responsibilities, and working together to improve the quality of services.</p> <p>The guidance also describes the new powers provided to local Healthwatch by the <u>Local Authorities (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013</u>, and describes how Health and Wellbeing Boards and local Healthwatch can work collaboratively with local government scrutiny committees to ensure that the views and concerns of patients and public are heard throughout the scrutiny process.</p> <p>The guidance is due to be published in November 2013.</p>	<p>to health scrutiny, and ensure that it adds value for local communities. The publication of the guidance was put back in order to ensure consistency with related policy around local consultation on proposals for service reconfiguration, and to allow additional engagement with local authorities and other system partners.</p> <p>The Department of Health, NHS England and Public Health England have jointly commissioned a programme of support for 2014/15 for local authorities in exercising their health scrutiny powers.</p>
148	The complexities of the health service are such that proper training must be available to the leadership of Local Healthwatch as well as, when the occasion arises, expert advice.	<p>Accepted.</p> <p>Healthwatch England is working to support local Healthwatch in their identification and analysis of issues in their communities and to support them to raise these issues in the appropriate manner. Already, local Healthwatch organisations are rightly working in partnership with local community and interest groups that have a wealth of expertise and experience available to them. Local Healthwatch organisations also have the flexibility to source expert advice as they require, while training and support is being made available through Healthwatch England.</p> <p>As an example of what has already been achieved, Healthwatch England has this year delivered training to local Healthwatch organisations across the country to ensure that they can maximise the impact of their power to enter and view local services.</p>	<p>Healthwatch England continues to provide support to local Healthwatch so that they can deliver effectively. During 2013/14 Healthwatch England provided training for local Healthwatch on entering and viewing local services and provided support across a range of other local Healthwatch activities. In 2014/15, Healthwatch England has delivered further training, for example on working with the Care Quality Commission inspection teams, and has also developed a network for local Healthwatch chairs.</p> <p>The Department has also funded the Local Government Association in 2014/15 to support the development of an effective local Healthwatch network, with a specific focus on supporting local Healthwatch to be effective members of local health and wellbeing boards.</p>
149	Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.	<p>Accepted.</p> <p>The Department of Health has worked with partners to develop guidance that will support local authorities to carry out effective scrutiny of the commissioning and delivery of local services, helping to ensure they are effective and safe.</p> <p>The guidance will help Local Authorities (along with local partners including NHS commissioners and providers, Health and Wellbeing Boards and Healthwatch) to understand the new powers and duties provided by the <u>Local Authorities (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013</u>.</p> <p>The Department is also delivering a range of programmes to increase the availability and transparency of data for local authorities, to support local democratic accountability including scrutiny processes.</p> <p>The guidance is due to be published in November 2013.</p>	<p>In June 2014, the Department issued <u>guidance</u> to local authorities on how to scrutinise local health systems. The guidance supports local government, the NHS and other local partners to understand and develop their roles in relation to health scrutiny, and ensure that it adds value for local communities. The publication of the guidance was put back in order to ensure consistency with related policy around local consultation on proposals for service reconfiguration, and to allow additional engagement with local authorities and other system partners.</p> <p>The Department of Health, NHS England and Public Health England have jointly commissioned a programme of support for 2014/15 for local authorities in exercising their health scrutiny powers.</p>
150	Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving	<p>Accepted in principle.</p> <p>Under current provisions, bodies carrying out local authority scrutiny functions have legal powers to require providers of NHS services to provide information and to attend scrutiny meetings to answer questions. This could include making a request to visit providers' premises. Where a body carrying out local authority</p>	<p>In June 2014, the Department issued <u>guidance</u> to local authorities on how to scrutinise local health systems. The guidance supports local government, the NHS and other local partners to understand and develop their roles in relation to health scrutiny, and ensure that it adds value for local communities. The publication of the guidance was put back in order to ensure consistency with related policy around local consultation on proposals for service</p>

	<p>reports without comment or suggestions for action.</p>	<p>scrutiny function had concerns about a specific provider, they could refer the matter to the Care Quality Commission, who have powers of inspection.</p> <p>Meanwhile, local Healthwatch has the power to enter and view certain premises, as well as powers to provide information and refer concerns to local authority scrutiny bodies.</p> <p>Giving further powers to local authorities would therefore be duplicative and potentially burdensome. It might also create confusion over roles and responsibilities.</p> <p>The work of Local Authority health scrutiny is already integral to ensuring an appropriate inspection regime is in place locally. By working collaboratively with both providers and local Healthwatch, local authority scrutiny bodies can ensure that concerns from patients and the public trigger further investigation where necessary.</p> <p>The Department of Health has worked with partners to develop guidance that will support local authorities to carry out effective scrutiny. The guidance describes the new powers and duties provided by the <u>Local Authorities (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013</u> and underlines the importance of all partners in the local system working together to improve the quality of services.</p> <p>The guidance is due to be published in November 2013.</p>	<p>reconfiguration, and to allow additional engagement with local authorities and other system partners.</p> <p>The Department of Health, NHS England and Public Health England have jointly commissioned a programme of support for 2014/15 for local authorities in exercising their health scrutiny powers.</p>
151	<p>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.</p>	<p>Accepted in principle.</p> <p>It is not for the Government to advise individual MPs on the systems they employ to identify the wider significance of individual complaints about health and care services. That said, the Department of Health recognises the invaluable insights which can be gained from letters written to MPs. Without wanting to suggest to MPs how they handle their own business, the Department would be willing to highlight the scope – for MPs who desired it or believed it appropriate – to identify themes and patterns in complaints by sharing correspondence with regulators (for example the Care Quality Commission, NHS Trust Development Authority and Monitor) using informed consent, and to gain intelligence about patient experience in their constituency’s health and care services by building strong relations with their local Healthwatch organisations. The Department would be willing to work with regulators and any interested MPs – while respecting their position as elected office holders- to share best practise and advice.</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>
152	<p>Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.</p>	<p>Accepted.</p> <p>In the new health and care system architecture, Memoranda of Understanding exist between key partners such as Health Education England and the Care Quality Commission, to share information and concerns about the quality and safety of providers. Memoranda of Understanding and other protocols for sharing information also exist between the Care Quality Commission and the General Medical Council and the Nursing and Midwifery Council. Health Education England will work with the system and professional regulators to develop these further.</p> <p>The recently established Quality Surveillance Groups bring together the different parts of the system to share information including shared views of risks to quality and any early warning signs of risk about poor quality. Health Education England as well as the system and professional regulators are members of the regional Quality Surveillance Groups.</p>	<p>The national guidance for the operation of Quality Surveillance Groups was updated in March 2014 to reflect early experience of sharing information between system regulators and commissioners. Early discussions about information causing concern are now occurring before meetings between local representatives of NHS England, the Care Quality Commission, Monitor and Health Education England, with some shared quality monitoring visits occurring where this is relevant.</p> <p>Quality Surveillance Groups are beginning to review health care economies rather than just acute care providers and plan themed meetings, considering specific risk areas across providers, for example the provision of intermediate care or older person’s services. Quality monitoring visits are also evolving - Health Education England is developing a multi-professional approach to visiting, encompassing the education and training culture and environment for all healthcare professionals.</p>

			As Health Education England and the Care Quality Commission refine their acute, community and primary care visiting processes, updated memoranda of understanding will be required and there will be increasing opportunities to incorporate experience of quality monitoring processes in to clinician's training. Health Education England is finalising the memoranda of understanding with the Care Quality Commission. Health Education England is also currently working with the professional regulators to develop a series of memoranda of understanding, where appropriate, to support the ongoing working relationships with the aim of promoting patient safety and high quality education and training.
153	The Secretary of State should by statutory instrument specify all medical education and training regulators as relevant bodies for the purpose of their statutory duty to cooperate. Information sharing between the deanery, commissioners, the General Medical Council, the Care Quality Commission and Monitor with regard to patient safety issues must be reviewed to ensure that each organisation is made aware of matters of concern relevant to their responsibilities.	<p>Accepted in principle.</p> <p>As stated in recommendation 152, in the new health and care system architecture, Memoranda of Understanding exist between key partners such as Health Education England and the Care Quality Commission, to share information and concerns about the quality and safety delivered of providers. The Health and Social Care Act 2012 further strengthened this by placing a statutory duty on Monitor and the Care Quality Commission to cooperate in the interests of patients. Monitor and Care Quality Commission have a Memorandum of Understanding in place to facilitate the necessary collaboration and information sharing. There are similar duties on organisations across the system, including Health Education England.</p> <p>The Care Quality Commission and the General Medical Council have published an operational protocol which sets out in detail how coordination and information sharing will work between the two regulators. A similar arrangement will be in place between the Care Quality Commission and the Nursing and Midwifery Council by December 2013, and updated information sharing arrangements thereafter between the Care Quality Commission, the General Dental Council and Health and Care Professions Council. Information from third parties such as the General Medical Council and the Royal Colleges is a potential trigger for regulatory intervention in Monitor's Risk Assessment Framework. Recently established Quality Surveillance Groups bring together the different parts of the system to share information, including shared views of risks to quality and any early warning signs of risk about poor quality. If any part of the local, regional or national system has concerns that there may be a serious quality failure within a provider organisation, which cannot be addressed through established and routine operational systems, a Risk Summit can be called.</p>	No further update is required. Please see response to the recommendation in Hard Truths
154	The Care Quality Commission and Monitor should develop practices and procedures with training regulators and bodies responsible for the commissioning and oversight of medical training to coordinate their oversight of healthcare organisations which provide regulated training.	<p>Accepted</p> <p>The Care Quality Commission and the General Medical Council have developed an operation protocol which describes when and how to share information on emerging and urgent concerns (for example about individual doctors, systems and environments) as well as processes for the routine sharing of information, local liaison meetings any on-going activities and risk summits. There is also a process for deciding when joint planned inspections are required. The Care Quality Commission is working on developing operational protocols with the Healthcare Professions Council and the Nursing and Midwifery Council.</p> <p>Information from third parties such as General Medical Council and Royal Colleges is a potential trigger for regulatory intervention in Monitor's Risk Assessment Framework and information and any identified concerns are shared with the Quality Surveillance Groups of which the General Medical Council and Nursing and Midwifery Council are also members of regional the Quality Surveillance Groups.</p>	<p>Memoranda of Understanding are being developed and revised with other strategic partner organisations, often supported by joint operating protocols. For example, a joint working protocol has recently been established with the Nursing and Midwifery Council and will be embedded during 2015. The Care Quality Commission is close to updating its joint working arrangements with the National Institute for Health and Care Excellence and the Health and Care Professionals Council, and the Care Quality Commission intelligence teams are liaising with the Health and Care Professionals Council on routine information sharing.</p> <p>Information from third parties such as the General Medical Council and Royal Colleges is a potential trigger for regulatory intervention in Monitor's Risk Assessment Framework and information and any identified concerns are shared with the quality surveillance groups of which the General Medical Council and Nursing and Midwifery Council are also members of regional the quality surveillance groups.</p>

155	<p>The General Medical Council should set out a standard requirement for routine visits to each local education provider, and programme in accordance with the following principles:</p> <ul style="list-style-type: none"> • The Postgraduate Dean should be responsible for managing the process at the level of the Local Educational Training Board, as part of overall deanery functions • The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required. • There should be lay or patient representation on visits to ensure that patient interests are maintained as the priority. • Such visits should be informed by all other sources of information and, if relevant, coordinated with the work of Care Quality Commission and other forms of review. <p>The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out.</p> <p>All healthcare organisations must be required to release healthcare professionals to support the visits programme. It should also be recognised that the benefits in professional development and dissemination of good practice are of significant value.</p>	<p>Accepted.</p> <p>The General Medical Council has stated its commitment to a thorough and consistent inspection regime, and to building on its quality assurance arrangements to address the issues raised in this recommendation.</p> <p>The General Medical Council is working with the Academy of Medical Royal Colleges and with Postgraduate Deans to develop a more explicit statement about how Colleges should support visits to local providers. The General Medical Council's Quality Improvement Framework is clear that Deans must draw on a range of external advice to support their scrutiny of local providers, including from patients and the public, as well as from doctors.</p> <p>The evidence pack supporting the General Medical Council inspection teams contain information from the Care Quality Commission and other external organisations. The outcomes of visits and information about serious concerns which the General Medical Council is monitoring are shared with the Care Quality Commission.</p> <p>In February 2012, the General Medical Council Chair, Professor Sir Peter Rubin, and the four UK Chief Medical Officers wrote a joint letter to NHS organisations setting out the importance of releasing clinical staff to perform roles that improve the overall quality of patient care, medical education and the effective running of the health service.</p>	<p>The General Medical Council considered this recommendation as part of its Review of Quality Assurance of Medical Education and Training. The final report was published on its website in February 2014 and work has begun to develop an action plan to address this recommendation. The plan will include different phases to:</p> <ul style="list-style-type: none"> • scope and understand the current appointment processes and training required by each part of the system • map the appointment processes and training undertaken and understand the similarities and differences. • agree a way forward with all concerned organisations designed to minimise the requirement to repeat generic training and develop a mechanism for co-badging visitors and inspectors for the future. The General Medical Council anticipate that this would help the move towards a more 'collective' assurance process for regulation in the future. <p>The General Medical Council are also considering how to enhance college support for visits to local providers and this will form part of the initial scoping to implement the recommendations from the final report.</p>
156	<p>The system for approving and accrediting training placement providers and programmes should be configured to apply the principles set out above.</p>	<p>Accepted.</p> <p>The General Medical Council are taking the response to this recommendation forward in detail through its <i>Review of Quality Assurance in Education</i>. The General Medical Council will share its proposals in the first half of 2014.</p>	<p>The General Medical Council is reviewing its standards of medical education and training, as set out in <i>Tomorrow's Doctors</i> and <i>The Trainee Doctor</i>. The review will be developing themes which will replace the current domains outlined in the standards. One of those themes is learning environment and culture, ensuring that educational environments are safe for patients and safe for learners. There have been a series of roundtable events this year with stakeholders to discuss each of these themes and there has been wide support for defining what a learning environment would look like. A new standards framework will be consulted on in early 2015.</p>
157	<p>The General Medical Council should set out a clear statement of what matters; deaneries are required to report to the General Medical Council either routinely or as they arise. Reports should include a description of all relevant activity and findings and not be limited to exceptional matters of perceived non-compliance with standards. Without a</p>	<p>Accepted.</p> <p>We accept this recommendation. The General Medical Council already has a structured reporting template supported by guidance setting out what Deans are required to report to the General Medical Council. It is considering, through its review of quality assurance in education, how it will improve the value of these reports so that the information required on issues such as concerns and good practice is able to be of most benefit. The General</p>	<p>The General Medical Council considered this recommendation as part of its Review of Quality Assurance of Medical Education and Training, the final report includes a recommendation that reports should give greater attention to the transparency and accessibility of information for patients and the public, students and trainees. As part of the action plan to strengthen the role of visits the General Medical Council:</p> <ul style="list-style-type: none"> • have introduced a document register section at the end of each visit report to detail which evidence documentation has been used and how it has

	<p>compelling and recorded reason, no professional in a training organisation interviewed by a regulator in the course of an investigation should be bound by a requirement of confidentiality not to report the existence of an investigation, and the concerns raised by or to the investigation with his own organisation.</p>	<p>Medical Council will share its proposals in the first half of 2014.</p>	<p>contributed to the findings</p> <ul style="list-style-type: none"> • have developed a 5 year visits schedule. • will pilot the General Medical Council inspection teams to observe the environment in which clinical teaching occurs. <p>The General Medical Council continues to work with Deans to improve reporting mechanisms and how information requested. In March 2014 the General Medical Council launched the enhanced monitoring profile which includes a status rating for serious concerns. An action plan is being implemented for sharing good practice.</p>
158	<p>The General Medical Council should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients.</p>	<p>Accepted.</p> <p>The General Medical Council has made it clear that it places a high priority on feedback from students and tutors in ensuring both quality education and patient safety, and will look to reinforce this through <i>its Review of Quality Assurance in Education</i>. The General Medical Council will share its proposals in the first half of 2014.</p>	<p>Students and clinicians in training are the eyes and ears of the service today and the safety leaders of the future. As they move around during their training, they can spot where safety doesn't seem to be a priority, there is poor communication, and the concerns of patients and staff are not being listened to. As the future stars of a stronger safety culture, they need to be trained not only in safe care of the patient in front of them – already central to training – but in all the elements crucial to creating safer clinical systems: understanding human factors, measurement and audit, effective multidisciplinary team working, safe handovers of care, learning from error and near misses, and the tools of improvement science.</p> <p>The General Medical Council is reviewing its standards of medical education and training, as set out in <i>Tomorrow's Doctors</i> and <i>The Trainee Doctor</i>. The review will consider the importance of student, Trainee and trainer feedback on their training experience, including supervision, support and learning opportunities. A new standards framework will be consulted on in early 2015.</p> <p>Currently two Local Education Training Boards have a live non-medical feedback system, with all other Local Education Training Boards gathering information by other means, including formal evaluations of placements, informal feedback to the Local Education Training Board and Higher Education Institutions as well as placement providers, questionnaires, focus groups, specific interviews as part of a quality assurance process, etc. This happens across all Local Education Training Boards, developed in partnership with relevant parties involved in the process of quality improvement. All Local Education Training Boards collect trainee intelligence through the National General Medical Council survey.</p> <p>Through the Health Education England Commission on Education and Training for Patient Safety comprehensive proposals for enhancing safety training for all health and care professionals are being brought forward, including producing a film to help staff and learners in the NHS to raise concerns if they experience or witness practice which puts patients at risk.</p> <p>The General Medical Council is working with the Medical Schools Council and key partners to ensure that medical students and doctors in training are supported to become the leading lights of excellence in safety, with students starting this autumn seen as patient safety champions from day one. The General Medical Council will showcase current best practice at its conference in March and publish a report. The 5000 new Health Foundation NHS improvement 'fellows' will work with medical educators to bring the most up-to-date knowledge on improving safety to the heart of training. The General Medical Council has focused on safety throughout its revised standards for education and training, published for consultation in January 2015, and expanded the questions on safety in its annual survey of all trainees. Through its visits to check the quality of medical education and training, it will work with providers to improve standards and tackle safety concerns, and its regional liaison service will expand its work with students and doctors in training on raising concerns and improving safety.</p>

159	<p>Surveys of medical students and trainees should be developed to optimise them as a source feedback of perceptions of the standards of care provided to patients. The General Medical Council should consult the Care Quality Commission in developing the survey and routinely share information obtained with healthcare regulators.</p>	<p>Accepted.</p> <p>The General Medical Council has made it clear that it views surveys of medical students and doctors in training as vital in assessing the quality of education and an important tool in evaluating the standards of care provided to patients. The General Medical Council is now including questions about the quality of care provided to patients in the National Training Survey. The General Medical Council also surveys medical students ahead of formal visits to their medical schools, and is committed to considering, by 2015, whether to survey all medical students, as is done with doctors in training, in 2015. The results of the National Training Survey of trainees are published on the General Medical Council's web site and are shared with other regulators such as the Care Quality Commission, for example, to support their recent inspections of Acute Hospitals.</p>	<p>The 2014 National Training Survey, now closed, achieved a response rate of over 98 % of trainees. Comments relating to patient safety and undermining have now been analysed and included in the General Medical Council's monitoring processes with Deaneries and Local Education Training Boards if appropriate. The General Medical Council published its key findings from the 2014 survey on their website in June. The results showed a rise in overall satisfaction levels from previous years, with overall scores for educational supervision, induction, handover and adequate experience improving. In November 2014 the General Medical Council published two further reports Concerns about patient safety which includes an analysis of the patient safety concerns raised and Undermining covering bullying and undermining behaviour and the General Medical Council's plans to work with others to combat this kind of behaviour in clinical environments.</p>
160	<p>Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.</p>	<p>Accepted.</p> <p>The General Medical Council has made clear its commitment to build on the progress to date in this area (the inclusion of a patient safety question in the National Training Survey, the development of new guidance on raising concerns and the introduction of a new confidential helpline for doctors), and recognises it needs to do more to raise awareness and encourage openness. Among other things the General Medical Council is running 'professionalism' events at all medical schools every year. The General Medical Council will also shortly be publishing a report highlighting the issue of bullying of trainees (which can lead to a culture in which trainees feel unable to raise concerns), illustrated by case studies showing the impact of such behaviour and how it can be tackled.</p>	<p>The encouragement of openness in trainees and protecting them from the potential adverse consequences of raising a concern was included in the 2014 Health Education England mandate. Health Education England has established a project group to deliver this. An audit has identified that systems are in place across LETBs and HEIs to allow students and learners to feedback on their experiences. In some cases, they can use a central online space for all placement related information, allowing students, LETBs and educators to access key information about their experiences. Students have strongly fed back that they value the various routes they have to discuss issues with those supporting them in their learning and are keen to maintain a duty of candour. Work is currently underway to develop, test and agree a standard set of core questions to be used with learners and a national set of principles for data collection to provide further consistency. Health Education England has also strengthened the routes to provide learner/trainee related information to the Care Quality Commission inspections. Trainee/learner feedback is also shared at system-wide Quality Surveillance Groups on a regular basis, so this is considered alongside other quality and safety measures. Further discussions involve how Health Education England can improve opportunities for non-medical undergraduates and post-graduate medical trainees where they are not already included in existing systems used for other students. The project is also monitoring the progress of RCP-led work to develop a 'trip advisor-style' website to seek real time feedback from junior doctors that may provide additional information to triangulate with existing sources.</p> <p>The General Medical Council's review of standards of medical education and training, has considered this recommendation by developing the draft standards in a way that emphasise the importance of ensuring the learning environment has a confidential process for raising concerns about the safety of patients or learners.</p> <p>It is very hard for staff to raise concerns where senior clinicians are dismissive, unsympathetic or worse. Doctors will be expected when they revalidate to demonstrate how they act on concerns raised with them, how they are reflecting on their practice and feedback from patients and colleagues, how they are fulfilling their professional duty of candour and supporting colleagues to do so too, and how their leadership skills and behaviours are contributing to creating an open safety culture that puts patients first.</p> <p>Additionally, the General Medical Council has commissioned the Rt Hon Sir Anthony Hooper to undertake a review of how it deals with doctors who raise concerns in the public interest. The review is expected to make recommendations as to how the General Medical Council's current guidance and processes might be adapted to reflect the needs of all doctors, including those in training, who raise concerns and ensure they, are appropriately supported. The review will hear the views of those who may have suffered as a result of raising concerns, as well as the perspective and experience of employers, trade unions</p>

			and professional leaders. The review is expected to complete shortly.
161	<p>Training visits should make an important contribution to the protection of patients:</p> <ul style="list-style-type: none"> • Obtaining information directly from trainees should remain a valuable source of information –but it should not be the only source of information used. • Visits to, and observation of, the actual training environment would enable visitors to detect poor practice from which both patients and trainees should be sheltered. • The opportunity can be taken to share and disseminate good practice with trainees and management. <p>Visits of this nature will encourage the transparency that is so vital to the preservation of minimum standards.</p>	<p>Accepted.</p> <p>The General Medical Council has made it clear that it views visits as an important tool within its quality assurance programme for assuring high quality training and protection of patients. The General Medical Council taken a policy decision to publish information on validated concerns about an educational setting on its website, and will implement this more transparent approach in late 2013 or early 2014. The General Medical Council's review of quality assurance in education is considering how to strengthen the role of visits and how the General Medical Council reports on them. The General Medical Council will share its proposals in the first half of 2014.</p>	<p>At the end of March 2014, the General Medical Council began publishing on its website information about validated education concerns that are subject to <u>enhanced monitoring</u> by the General Medical Council. Cases subject to enhanced monitoring relate by the General Medical Council. Cases subject to enhanced monitoring relate to patient safety or quality of education issues in a local education provider and can come from a variety of sources (visits, routine monitoring, Deanery Reports). The aim of publishing this information is to increase the transparency of our monitoring process. A quarterly publishing system is now in place.</p> <p>This recommendation was considered as part of the General Medical Council's Review of Quality Assurance of Medical Education and Training. The final report of the review includes a recommendation that reports should give greater attention to the transparency and accessibility of information for patients and the public, students and trainees. As part of the action plan to strengthen the role of visits the General Medical Council:</p> <ul style="list-style-type: none"> • have introduced a document register section at the end of each visit report to detail which evidence documentation has been used and how it has contributed to the findings • have developed a 5 year visits schedule. • will pilot the General Medical Council inspection teams to observe the environment in which clinical teaching occurs.
162	<p>The General Medical Council should in the course of its review of its standards and regulatory process ensure that the system of medical training and education maintains as its first priority the safety of patients. It should also ensure that providers of clinical placements are unable to take on students or trainees in areas which do not comply with fundamental patient safety and quality standards. Regulators and deaneries should exercise their own independent judgement as to whether such standards have been achieved and if at any stage concerns relating to patient safety are raised, they must take appropriate action to ensure these concerns are properly addressed.</p>	<p>Accepted.</p> <p>The General Medical Council has made it clear that it agrees that this is a fundamentally important principle which is given prominence in its guidance for doctors. The General Medical Council is considering as part of its review of quality assurance in education how it can be assured of the adequacy and appropriateness of training environments. The General Medical Council will share its proposals in the first half of 2014.</p>	<p>Students and clinicians in training are the eyes and ears of the service today and the safety leaders of the future. As they move around during their training, they can spot where safety doesn't seem to be a priority, there is poor communication, and the concerns of patients and staff are not being listened to. As the future stars of a stronger safety culture, they need to be trained not only in safe care of the patient in front of them – already central to training – but in all the elements crucial to creating safer clinical systems: understanding human factors, measurement and audit, effective multidisciplinary team working, safe handovers of care, learning from error and near misses, and the tools of improvement science.</p> <p>Through the Health Education England Commission on Education and Training for Patient Safety, the General Medical Council will bring together comprehensive proposals for enhancing safety training for all health and care professionals, including producing a film to help staff and learners in the NHS to raise concerns if they experience or witness practice which puts patients at risk. The General Medical Council, Medical Schools Council, Foundation Programme and Royal Colleges are working across the UK to ensure that medical students and doctors in training are supported to become the leading lights of excellence in safety, with students starting this autumn seen as patient safety champions from day one. The General Medical Council will showcase current best practice at its conference in March and publish a report. The 5000 new Health Foundation NHS Improvement 'fellows' will work with medical educators to bring the most up-to-date knowledge on improving safety to the heart of training. The General Medical Council has focused on safety throughout its revised standards for education and training, published for consultation in January 2015, and expanded the questions on safety in its annual survey of all trainees. Through its visits to check the quality of medical education and training, it will work with providers to improve standards and tackle safety concerns, and its regional liaison service will expand its work with students and doctors in training on raising concerns and improving safety.</p>

			It is very hard for staff to raise concerns where senior clinicians are dismissive, unsympathetic or worse. Doctors will be expected when they revalidate to demonstrate how they act on concerns raised with them, how they are reflecting on their practice and feedback from patients and colleagues, how they are fulfilling their professional duty of candour and supporting colleagues to do so too, and how their leadership skills and behaviours are contributing to creating an open safety culture that puts patients first.
163	The General Medical Council's system of reviewing the acceptability of the provision of training by healthcare providers must include a review of the sufficiency of the numbers and skills of available staff for the provision of training and to ensure patient safety in the course of training.	Accepted. The General Medical Council's standards for training includes (at Domain 8) educational resources and capacity and provides that there must be a suitable ratio of trainers to trainees. The General Medical Council has made it clear that it will use its <i>Review of Quality Assurance in Education</i> to consider whether the standard should be more specific while allowing necessary scope for local flexibility.	The General Medical Council is reviewing its standards of medical education and training, as set out in <i>Tomorrow's Doctors</i> and The <i>Trainee Doctor</i> . The review will be developing themes which will replace the current domains outlined in the standards. One of those themes is support for learning and training, ensuring that each doctor in training has dedicated support to acquire the necessary skills and experience, personal support and time to learn. These themes aim to be more specific than the current domains. A new standards framework was launched for consultation in January 2015.
164	The Department of Health and the General Medical Council should review whether the resources available for regulating Approved Practice Setting are adequate and, if not, make arrangements for the provision of the same. Consideration should be given to empowering the General Medical Council to charge organisations a fee for approval.	Accepted in principle. The General Medical Council has undertaken a fundamental review of Approved Practice Settings. This review considered Approved Practice Settings in the context of the General Medical Council's functions and how they promote assurance and patient safety. Since Approved Practice Settings was introduced in 2007, the General Medical Council has acquired significant powers relating to quality assuring medical training environments the Responsible Officer regulations have come into force and revalidation has begun. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. It represents a major step forward in the quality assurance of practising doctors. The General Medical Council review has found that these new powers have superseded Approved Practice Settings as a source of regulatory assurance and has recommended that the legal provisions that deal with Approved Practice Settings should be reviewed as part of the Law Commission review of the regulation of health and social care professionals. This will however take time, and in the meantime there is an opportunity for the General Medical Council to align the Approved Practice Settings requirements with those in the Responsible Officer Regulations. In effect, this would mean that newly registered doctors or doctors recently restored to the register must, while in the UK, practise in circumstances where they have a connection to a designated body, which is an organisation that will provide regular appraisal and help with revalidation.	Following the General Medical Council's fundamental review of Approved Practice Settings (APS), new APS requirements were introduced in June 2014. These align the APS regime with the Responsible Officer Regulations. Doctors subject to APS requirements must now hold a prescribed connection to a designated body in order to practice in the UK. Designated bodies are, for the most part, organisations that employ or contract with licensed doctors. They are under a statutory duty to have systems in place to support the continuous evaluation of all doctors with a connection to their organisation. They must have an appraisal system in place for these doctors and support them with their revalidation. This ensures that these doctors are subject to the clinical governance arrangements required for revalidation, such as regular appraisals based on the General Medical Council's core guidance for doctors, and are no longer restricted to practising in a specific physical setting. The Law Commission's report and draft Bill were published on 2 April 2014. The Law Commission made 125 recommendations intended to simplify and modernise the UK law relating to the regulation of health care professionals and, in England only, the regulation of social workers. The Government responded to this report on January 29 th 2015 and legislation will be brought forward when Parliamentary time allows. Because the General Medical Council are using this alternative model for newly registered doctors, or doctors recently restored to the register, the issue of charging is no longer relevant.
165	The General Medical Council should immediately review its approved practice settings criteria with a view to recognition of the priority to be given to protecting patients and the public.	Accepted in principle. The priority should, as in all regulatory activity, be protecting patients and the public. The General Medical Council has undertaken a fundamental review of Approved Practice Settings. This review considered Approved Practice Settings in the context of the General Medical Council's functions and how they promote assurance and patient safety. Since Approved Practice Settings was introduced in 2007, the General Medical Council has acquired significant powers relating to quality assuring medical training environments the Responsible Officer regulations have come into force and revalidation has begun. Revalidation is the process by which licensed doctors are required to demonstrate on a regular	Following the General Medical Council's fundamental review of Approved Practice Settings (APS), new APS requirements were introduced in June 2014. These align the APS regime with the Responsible Officer Regulations. Doctors subject to APS requirements must now hold a prescribed connection to a designated body in order to practice in the UK. Designated bodies are, for the most part, organisations that employ or contract with licensed doctors. Designated bodies are under a statutory duty to have systems in place to support the continuous evaluation of all doctors with a connection to their organisation. They must have an appraisal system in place for these doctors and support them with their revalidation.

		<p>basis that they are up to date and fit to practise. It represents a major step forward in the quality assurance of practising doctors.</p> <p>The General Medical Council review has found that these new powers have superseded Approved Practice Settings as a source of regulatory assurance and has recommended that the legal provisions that deal with Approved Practice Settings should be reviewed as part of the Law Commission review of the regulation of health and social care professionals. This will however take time, and in the meantime there is an opportunity to align the Approved Practice Settings requirements with those in the Responsible Officer Regulations. In effect, this would mean that newly registered doctors or doctors recently restored to the register must, while in the UK, practise in circumstances where they have a connection to a designated body, which is an organisation that will provide regular appraisal and help with revalidation.</p>	<p>This ensures that these doctors are subject to the clinical governance arrangements required for revalidation, such as regular appraisals based on the General Medical Council's core guidance for doctors, and are no longer restricted to practising in a specific physical setting (and should be clearer for doctors and the organisations that they employ or contract with them).</p> <p>The Law Commission's report and draft Bill were published on 2 April 2014. The Law Commission made 125 recommendations intended to simplify and modernise the UK law relating to the regulation of health care professionals and, in England only, the regulation of social workers. The Government responded to this report on January 29th 2015 and legislation will be brought forward when Parliamentary time allows.</p>
166	<p>The General Medical Council should in consultation with patient interest groups and the public immediately review its procedures for assuring compliance with its approved practice settings criteria with a view in particular to provision for active exchange of relevant information with the healthcare systems regulator, coordination of monitoring processes with others required for medical education and training, and receipt of relevant information from registered practitioners of their current experience in approved practice settings approved establishments.</p>	<p>The General Medical Council has undertaken a fundamental review of Approved Practice Settings. This review considered Approved Practice Settings in the context of the General Medical Council's functions and how they promote assurance and patient safety. Since Approved Practice Settings was introduced in 2007, the General Medical Council has acquired significant powers relating to quality assuring medical training environments the Responsible Officer regulations have come into force and revalidation has begun. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. It represents a major step forward in the quality assurance of practising doctors.</p> <p>The General Medical Council review has found that these new powers have superseded Approved Practice Settings as a source of regulatory assurance and has recommended that the legal provisions that deal with Approved Practice Settings should be reviewed as part of the Law Commission review of the regulation of health and social care professionals. This will however take time, and in the meantime there is an opportunity to align the Approved Practice Settings requirements with those in the Responsible Officer Regulations. In effect, this would mean that newly registered doctors or doctors recently restored to the register must, while in the UK, practise in circumstances where they have a connection to a designated body, which is an organisation that will provide regular appraisal and help with revalidation.</p> <p>The General Medical Council has emphasised its commitment to working with other regulators as effectively as possible in the interests of patients.</p>	<p>Following the General Medical Council's fundamental review of Approved Practice Settings (APS), new APS requirements were introduced in June 2014. These align the APS regime with the Responsible Officer Regulations. Doctors subject to APS requirements must now hold a prescribed connection to a designated body in order to practice in the UK. Designated bodies are, for the most part, organisations that employ or contract with licensed doctors. Designated bodies are under a statutory duty to have systems in place to support the continuous evaluation of all doctors with a connection to their organisation. They must have an appraisal system in place for these doctors and support them with their revalidation.</p> <p>This ensures that these doctors are subject to the clinical governance arrangements required for revalidation, such as regular appraisals based on the General Medical Council's core guidance for doctors, and are no longer restricted to practising in a specific physical setting and should be clearer for doctors and the organisations that they employ or contract with them.</p> <p>The Law Commission's report and draft Bill were published on 2 April 2014. The Law Commission made 125 recommendations intended to simplify and modernise the UK law relating to the regulation of health care professionals and, in England only, the regulation of social workers. The Government responded to this report on January 29th 2015 and legislation will be brought forward when Parliamentary time allows.</p>
167	<p>The Department of Health and General Medical Council should review the powers available to the General Medical Council in support of assessment and monitoring of approved practice settings establishments with a view to ensuring that the General Medical Council (or if considered more appropriate, the healthcare systems regulator), has the power to inspect establishments, either itself or by an appointed entity on its behalf, and to require the production of relevant information.</p>	<p>Accepted in principle.</p> <p>The General Medical Council has undertaken a fundamental review of Approved Practice Settings. This review considered Approved Practice Settings in the context of the General Medical Council's functions and how they promote assurance and patient safety. Since Approved Practice Settings was introduced in 2007, the General Medical Council has acquired significant powers relating to quality assuring medical training environments the Responsible Officer regulations have come into force and revalidation has begun. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. It represents a major step forward in the quality assurance of practising doctors.</p> <p>The General Medical Council review has found that these new powers have superseded Approved Practice Settings as a source of regulatory assurance and has recommended that the legal provisions that deal with Approved Practice Settings should be reviewed as part of the Law Commission review of the regulation of health and social care professionals. This will however take time, and in the meantime there is an opportunity to align the Approved Practice Settings requirements with those in the Responsible Officer Regulations. In effect, this would mean that newly registered</p>	<p>Following the General Medical Council's fundamental review of Approved Practice Settings (APS), new APS requirements were introduced in June 2014. These align the APS regime with the Responsible Officer Regulations. Doctors subject to APS requirements must now hold a prescribed connection to a designated body in order to practice in the UK. Designated bodies are, for the most part, organisations that employ or contract with licensed doctors. Designated bodies are under a statutory duty to have systems in place to support the continuous evaluation of all doctors with a connection to their organisation. They must have an appraisal system in place for these doctors and support them with their revalidation.</p> <p>This ensures that these doctors are subject to the clinical governance arrangements required for revalidation, such as regular appraisals based on the General Medical Council's core guidance for doctors, and are no longer restricted to practising in a specific physical setting and should be clearer for doctors and the organisations that they employ or contract with them.</p> <p>The Care Quality Commission has a key responsibility in the overall assurance of levels of safety and quality of health and adult social care services. The Care Quality Commission already has powers to enter and inspect premises under the</p>

		doctors or doctors recently restored to the register must, while in the UK, practise in circumstances where they have a connection to a designated body, which is an organisation that will provide regular appraisal and help with revalidation.	<p>Health and Social Care Act 2008, section 62(2), which states 'A person authorised by the Commission may enter and inspect any premises which are, or which the person reasonably believes to be, regulated premises'. This will normally be a health or care home setting.</p> <p>The Law Commission's report and draft Bill were published on 2 April 2014. The Law Commission made 125 recommendations intended to simplify and modernise the UK law relating to the regulation of health care professionals and, in England only, the regulation of social workers. The Government responded to this report on January 29th 2015 and legislation will be brought forward when Parliamentary time allows.</p>
168	The Department of Health and the General Medical Council should consider making the necessary statutory (and regulatory changes) to incorporate the approved practice settings scheme into the regulatory framework for post graduate training.	<p>Accepted in principle.</p> <p>The General Medical Council has undertaken a fundamental review of Approved Practice Settings. This review considered Approved Practice Settings in the context of the General Medical Council's functions and how they promote assurance and patient safety. Since Approved Practice Settings was introduced in 2007, the General Medical Council has acquired significant powers relating to quality assuring medical training environments the Responsible Officer regulations have come into force and revalidation has begun. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. It represents a major step forward in the quality assurance of practising doctors.</p> <p>The General Medical Council review has found that these new powers have superseded Approved Practice Settings as a source of regulatory assurance and has recommended that the legal provisions that deal with Approved Practice Settings should be reviewed as part of the Law Commission review of the regulation of health and social care professionals. This will however take time, and in the meantime there is an opportunity to align the Approved Practice Settings requirements with those in the Responsible Officer Regulations. In effect, this would mean that newly registered doctors or doctors recently restored to the register must, while in the UK, practise in circumstances where they have a connection to a designated body, which is an organisation that will provide regular appraisal and help with revalidation.</p>	<p>Following the General Medical Council's fundamental review of Approved Practice Settings new Approved Practice Settings requirements were introduced in June 2014. These align the Approved Practice Settings regime with the Responsible Officer Regulations. Doctors subject to Approved Practice Settings requirements must now hold a prescribed connection to a designated body in order to practise in the UK. Designated bodies are, for the most part, organisations that employ or contract with licensed doctors. Designated bodies are under a statutory duty to have systems in place to support the continuous evaluation of all doctors with a connection to their organisation. They must have an appraisal system in place for these doctors and support them with their revalidation.</p> <p>This ensures that these doctors are subject to the clinical governance arrangements required for revalidation, such as regular appraisals based on core General Medical Council guidance for doctors, and are no longer restricted to practising in a specific physical setting and should be clearer for doctors and the organisations that they employ or contract with them.</p> <p>The Care Quality Commission has a key responsibility in the overall assurance of levels of safety and quality of health and adult social care services. The Care Quality Commission already has powers to enter and inspect premises under the Health and Social Care Act 2008, section 62(2), which states 'A person authorised by the Commission may enter and inspect any premises which are, or which the person reasonably believes to be, regulated premises'. This will normally be a health or care home setting.</p> <p>The Law Commission's report and draft Bill were published on 2 April 2014. The Law Commission made 125 recommendations intended to simplify and modernise the UK law relating to the regulation of health care professionals and, in England only, the regulation of social workers. The Government responded to this report on January 29th 2015 and legislation will be brought forward when Parliamentary time allows.</p>
169	The Department of Health, through the National Quality Board, should ensure that procedures are put in place for facilitating the identification of patient safety issues by training regulators and cooperation between them and healthcare systems regulators.	<p>Accepted in principle.</p> <p>The National Quality Board brings together a number of key national partners, including the Care Quality Commission, the Nursing and Midwifery Council and the General Medical Council to champion quality and ensure alignment in quality throughout the NHS.</p> <p>The General Medical Council and the Nursing and Midwifery Council both participate in regional quality surveillance groups. These groups bring together commissioners, regulators, local Healthwatch representatives and other bodies on a regular basis to share information and intelligence about quality across the system, including the views of patients and the public.</p>	<p>The General Medical Council collects a rich and unique data set that can yield intelligence about systems or generic concerns and has developed a data strategy setting out how it will develop and use data. This work is in its early stages but, over time, is expected to allow the General Medical Council to identify, analyse and understand trends and areas of risk. It will use this intelligence to develop the way it regulates and reflect it back to the medical profession (and, importantly) the wider healthcare system. (See Recommendation 222)</p> <p>Additionally, the General Medical Council has established an internal Patient Safety Intelligence Forum to coordinate information that may demonstrate concerns about patient safety or medical practice and ensure the appropriate</p>

		<p>The General Medical Council has made it clear that it recognises the need to contribute to the identification and in some cases the investigation of generic concerns, building on its progress in recent years to become a more proactive and collaborative regulator. This includes signposting complainants to the appropriate regulator if their concerns are not for the General Medical Council; making referrals to systems or other professional regulators; investigating concerns arising from the media (including those which do not specifically name a doctor) and sharing information with and participating in regional quality surveillance groups and risk summits.</p> <p>The Nursing and Midwifery Council have made it clear that they are determined to work closely with other regulators; including the Care Quality Commission to share information and analyses, and that it should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures.</p> <p>In addition, as set out in the responses to recommendations 164 and 165, the General Medical Council has undertaken a fundamental review of Approved Practice Settings and the final recommendation is that the provisions of section of the Medical Act 1983, which deals with Approved Practice Settings, should be repealed through the next available legislative vehicle. In the meantime, the General Medical Council will place the scheme on a firmer footing through alignment with the existing statutory duties for healthcare organisations, namely the Responsible Officer Regulations. This would, in effect, prevent doctors newly registered or recently restored to the register from practising in circumstances where they do not have a prescribed connection to a designated body (a prescribed connection means making sure every licensed doctor is supported with revalidation and that they are always working in an environment that monitors and improves the quality of its services). The General Medical Council will also build on its relationships with systems regulators in each of the four countries – they have an important role in ensuring that organisations comply with the duties for designated bodies set out in the Responsible Officer regulations.</p>	<p>operational and policy response across its functions relevant to operational or thematic risk. This Forum will continue to develop throughout 2015 in parallel with the development of the organisation's enhanced data strategy.</p> <p>The General Medical Council has also been strengthening its relationships and ways of working with the Care Quality Commission and other organisations. It has already developed an Operational Protocol with the Care Quality Commission and held a workshop to identify thresholds for sharing information which has led to further opportunities to develop its information sharing protocol.</p>
170	Health Education England should have a medically qualified director of medical education and a lay patient representative on its board.	<p>Accepted.</p> <p>Health Education England employs a medically qualified Director of Education and Quality who is responsible for all professional education and training. Professor Chris Welsh currently occupies this post and is supported by a Director of Nursing and a Director of Medical Education. He took up this post in April 2013. Health Education England also has a clinically qualified Director of Nursing and Medical Director.</p> <p>Mary Elford has been appointed as a Non-Executive Director for the board of Health Education England and will have a specific focus on the interests of patients and service users. She began in this role on 1 September 2013. Mary will chair Health Education England's new national patient forum, to incorporate the views of patients into the education and training programme.</p>	Health Education England employs a medically qualified Director of Education & Quality who is accountable for all professional education and training. Professor Wendy Reid currently occupies the post of Director of Education & Quality and Medical Director; this role is supported by the Director of Nursing, Professor Lisa Bayliss-Pratt. Wendy assumed the responsibilities of Director of Education & Quality in April 2014 following the retirement of Professor Chris Welsh.
171	All Local Education and Training Boards should have a post of medically qualified postgraduate dean responsible for all aspects of postgraduate medical education.	<p>Accepted.</p> <p>All Local Education and Training Boards do have a qualified postgraduate dean responsible for postgraduate medical education and training.</p> <p>However, a multi-professional approach to education and training is important. Although Local Education and Training Boards have a dean looking after the specifics of postgraduate medical education, they are part of a multi-professional team under the leadership of a Director of Education and Quality who is responsible for all education and training.</p>	No further update is required. Please see response to the recommendation in Hard Truths
172	The Government should consider urgently the	Accepted.	In 2013 the General Medical Council consulted on the principle of ensuring that

	<p>introduction of a common requirement of proficiency in communication in the English language with patients and other persons providing healthcare to the standard required for a registered medical practitioner to assume professional responsibility for medical treatment of an English-speaking patient.</p>	<p>The Department of Health has been working with the General Medical Council to ensure that all doctors working in the UK have the necessary knowledge of English to treat patients safely.</p> <p>Overseas doctors (non-EU) are currently required to demonstrate that they have the necessary language skills before they are registered with the General Medical Council. The Government wishes to ensure that all doctors (including EU nationals) working in the UK has the necessary knowledge of English to treat patients in a safe and competent manner and the Department of Health has been working with the General Medical Council to achieve this policy.</p> <p>The Department of Health launched its consultation paper <i>Language Controls for Doctors: Proposed Changes to the Medical Act 1983</i> on 7 September, seeking amendments to the <i>Medical Act 1983</i>. The proposals will give the General Medical Council the power to require evidence of English language capability as part of the licensing process where concerns about language have been identified during the registration process; and create a new category of impairment relating to the necessary knowledge of English, strengthening the General Medical Council's ability to take fitness to practise action where concerns about language competence are identified.</p> <p>Also, the new <i>National Health Service (Performers List) (England) Regulations</i> have been streamlined and will allow NHS England to nationally refuse to include a GP on its list where it is not satisfied that they have sufficient knowledge of the English language necessary to perform their work.</p> <p>The initial focus has been on arrangements for doctors however, we are committed to ensuring all healthcare professionals coming to work in the UK can speak English well enough to communicate with patients. The revision of the Mutual Recognition of Professional Qualifications (MRPQ) Directive, which impacts on registrations from within the European Economic Area, clarifies that healthcare regulators, can undertake proportionate language controls on professionals following registration.</p>	<p>all licensed doctors have the necessary knowledge of English to practise safely in the UK. Following the consultation, which received strong support, new checks came into force on 25 June 2014. The changes will require doctors from other European countries to provide evidence of their English skills or undergo a language assessment, if the General Medical Council has concerns about his or her ability to communicate effectively with their patients.</p> <p>The General Medical Council also announced in February 2014 that they are raising the scores for overseas doctors who take the International English Language Testing System test to demonstrate their English language skills, in light of the results of some research they commissioned. From June 2014, doctors will need to achieve an overall score of 7.5 out of 9 rather than the current score of 7. This change will help to ensure that patients are treated by doctors who can speak and communicate in English to a sufficiently high standard. They will continue to keep the score they require under review.</p>
173	<p>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.</p>	<p>Accepted.</p> <p>Promoting honesty, openness and transparency, and instilling a culture that values compassion, dignity and the highest quality of care is one the key responsibilities of the Department of Health as part of its role in championing improvement and innovation in health. In , <i>Patients First and Foremost</i>, the Government's initial response to the Inquiry, leaders of health and social care organisations signed up to a Statement of Common Purpose that included reaffirming their commitment to putting patients first before the interest of their organisations and to uphold the value that patients are best served where there is a culture of candour, openness, honesty and acceptance of challenge. In <i>A new start – Consultation on changes to the way Care Quality Commission regulates, inspects and monitors care</i>, the Care Quality Commission proposed a framework for inspection which includes a judgement of organisations based on their ability to promote an open, fair and transparent culture.</p> <p>Openness and honesty is already a requirement in healthcare professionals' codes of practice and the principles and the NHS Constitution already emphasises the importance of honesty and openness. The Education Outcomes Framework and in turn, the Mandate for Health Education England also identifies recruitment, education, training and development that are consistent with the values and behaviours identified in the NHS Constitution as a key deliverable.</p>	<p>The Department of Health and the wider health and care system remains committed to being transparent and open about the safety and quality of services. The public now has a single authoritative view about the quality and safety of healthcare services. From April 2014, the Care Quality Commission began rating hospitals' quality of care in bands ranging from outstanding to inadequate and the full roll out of ratings for hospitals, and ratings for social care and GPs began to be used from October 2014. The NHS in England is also the first health system in the world to measure its commitment to an 'open and honest reporting' on a national scale. And there has been a push to achieve an unprecedented level of transparency. Patient safety information is now on NHS Choices together with information about infection control and cleanliness, whether patients are assessed for risk of blood clots, how trusts perform on whether their staff would recommend the trust, how they respond to patient safety alerts and ward-by-ward level information about nursing and midwifery staff levels. The Consultant Outcomes Publication began with ten national clinical audits in June 2013 and this has now increased to 12 specialties. Over 99 percent of consultants have agreed or not objected to information regarding their practice being published. The statutory duty of candour announced in November 2013 came into force for NHS trusts from November 2014 and will come into force for all other organisations from April 2015.</p> <p>The latest results of the NHS Staff Survey show that overall, 85% (86% in 2012) of all staff felt encouraged by their organisation to report errors, near misses and incidents. Only 14% of all staff felt that reporting of errors would lead to punishment or blaming of those involved. The Nuffield Trust survey of</p>

			NHS acute trusts one year post the Francis Report found that many of the themes from the Francis Inquiry Report, including the importance of openness, staffing levels and a patient-centered culture, have resonated with leaders of the hospitals
174	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	<p>Accepted.</p> <p>The Secretary of State for Health legally required NHS England to insert a contractual duty of candour into the NHS Standard Contract in 2013–14. This means that NHS Trusts and Foundation Trusts are contractually required to operate a duty of candour. The contract also refers organisations to the <i>Being Open</i> framework that was first produced by the National Patient Safety Agency. This provides guidance on best practice for all healthcare organisations to create an environment where patients, their carers, healthcare professionals and managers all feel supported when things go wrong and have the confidence to act appropriately. The framework gives healthcare organisations guidance on how to develop and embed a being open policy that fits local organisational circumstances. Another key element of the framework is the process on how to communicate with patients, their families and carers following harm.</p> <p>The Government has also introduced in the Care Bill a new requirement for a statutory duty of candour and will be included as a new registration requirement for health and social care providers registered with the Care Quality Commission. The duty will require providers to be open with patients and service users about failings in care provide an explanation, and where appropriate an apology. As a mark of the Government's commitment to the duty of candour, the Care Bill puts a requirement on the Secretary of State for Health to establish a requirement for registered with the Care Quality Commission to meet a duty of candour</p>	The Government has put in place a new statutory duty of candour as a requirement for registration with the Care Quality Commission which applies to NHS organisations now and all other organisations from April 2015. The threshold for the new duty will be in line with the recommendations of the review led by Professor Sir Norman Williams, President of the Royal College of Surgeons, and Sir David Dalton, Chief Executive at Salford Royal NHS Foundation Trust into enhancing candour in the NHS: <u><i>Building a culture of candour: A review of the threshold for the duty of candour and of the incentives for care organisations to be candid</i></u> published on 6 March 2014.
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).	<p>Accepted.</p> <p>All regulated professionals through the principles that underpin their standards and codes of conduct are required to be open and transparent with patients in respect of discussions about treatment and care. As set out in recommendation 181, the General Medical Council and the Nursing and Midwifery Council will be working with the other regulators to agree consistent approaches to candour and reporting of errors, including a common responsibility across doctors, nurses and other health professions to be candid with patients when mistakes occur whether serious or not. The Department of Health will also ask the Professional Standards Authority to advise and report on progress with this work. The professional regulators will also review their guidance to panels taking decisions on professional misconduct to ensure they take proper account of whether or not professionals have raised concerns promptly.</p>	Eight UK professional healthcare regulators published a joint statement in October 2014 which sets out a <u>professional duty of candour</u> . The statement clarifies what the regulators expect from health professionals wherever they work across the public, private and voluntary sectors. In addition, the General Medical Council and the Nursing and Midwifery Council have launched a public consultation on draft joint guidance which is designed to support doctors, nurses and midwives in fulfilling their professional duty to be open and honest about mistakes. The proposals cover the need to learn from 'near misses' as well as when something goes wrong and a patient is harmed. There is also advice on apologising to patients and those close to them. The draft guidance calls on clinical leaders and employers to support doctors, nurses and midwives by creating cultures in the workplace that are open, honest, and where people learn from mistakes so that future patients are protected from harm. The consultation closed on 05 January 2015 and the two professional regulators will aim to publish their new joint guidance in March 2015.
176	Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.	<p>Accepted.</p> <p>The Government's response to the Inquiry, <i>Patients First and Foremost</i> reaffirmed a commitment to the values of openness, honesty and acceptance of challenge and when things go wrong to learn from and not conceal mistakes. There is a clear expectation that every health and care provider should abide by these values. There is a similar expectation of truthfulness between commissioners and providers – service condition 4.1 of the NHS Standard Contract is explicit that 'Parties must at all times act in good faith towards each other' and between providers and regulators. Also, the Care Quality Commission will assess whether providers have an open and transparent culture, backed up by effective leadership, governance and clinical involvement as part of its new approach to inspection and regulation. As set out in recommendation 182, the</p>	The Government is putting in place a new criminal offence applicable to any care providers who supply, publish or otherwise make available certain types of information which is false or misleading, where that information is required to comply with a statutory or other legal obligation. This offence also applies to senior individuals in a provider organisation if they consent or connive in the offence. Further information is set out in the update to the response to recommendation 182.

		Government is putting in place additional measures to ensure that certain key information is truthful and not misleading. There is an existing requirement of Monitor's licence that information provided is accurate, complete and not misleading and an expectation that licence-holders notify Monitor in the event of any incident, event or report that may raise concerns over compliance with their licence. The Care Bill contains provisions to introduce a new criminal offence applicable to care providers that supply or publish certain types of false or misleading information, where that information is required to comply with a statutory or other legal obligation.	
177	Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	<p>Accepted.</p> <p>Accountability is a key leadership role and effectively means organisations operate effectively and with openness, transparency and candour at all times.</p> <p>The NHS Leadership Academy's guide, <i>The Healthy NHS Board 2013 – Principles for Good Governance</i> describes the principles of high quality governance that all care providers should be implementing. The board of a healthcare organisation itself will be held to account by a wide range of stakeholders, for the overall effectiveness and performance of the organisation that it oversees, and the extent to which the board and the organisation operates with openness, transparency and candour. One key part of accountability is the need for the board to ensure that published figures on all aspects of the quality of care are accurate and provide an honest and fair account to commissioners, regulators, patients and the public.</p> <p>As set out in recommendation 182, the Government is putting in place additional measures to ensure that certain key information is truthful and not misleading. The Care Bill contains provisions to introduce a new criminal offence applicable to care providers that supply or publish certain types of false or misleading information, where that information is required to comply with a statutory or other legal obligation.</p>	As set out the updated response to recommendation 182, the Government is putting in place a new criminal offence applicable to any care providers who supply, publish or otherwise make available certain types of information which is false or misleading, where that information is required to comply with a statutory or other legal obligation. This offence also applies to senior individuals in a provider organisation if they consent to or connive in the offence. The aim is to bring this offence into force in early 2015.
178	The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations.	<p>Accepted in principle.</p> <p>We agree that staff should be honest and open with patients, and <i>The NHS Constitution</i> already emphasises the importance of honesty and openness in its values and sections outlining staff responsibilities, rights and pledges. In addition, wording was included in the March 2013 update of <i>The NHS Constitution</i> to reflect the contractual duty of candour.</p> <p>We note that the Inquiry has made a number of recommendations which relate to openness and transparency in policies and guidance of providers and other healthcare organisations, along with the reporting processes of these organisations and how they interact with regulators. While we generally agree with the importance of these recommendations, <i>The NHS Constitution</i> focuses specifically on setting out the values of the NHS along with the rights and pledges to patients and staff, and their responsibilities. As it is not intended to address organisational reporting processes and interactions with regulatory bodies, it is not considered appropriate to reflect these issues in <i>The NHS Constitution</i>.</p> <p>If, as is currently planned, a new legal duty of candour is created, we will consult on how best to reflect this in <i>The NHS Constitution</i> when it is next updated.</p> <p>We do not think that including a duty of openness, transparency and candour into contracts of employment is relevant, not least because of the difficulty in defining these terms for contractual purposes. We think that this recommendation can be best delivered through improved appraisal and, for example, revalidation arrangements being developed by the Nursing and Midwifery Councils (see response to recommendation 193) and other professional regulators. Steps have</p>	<p>Sir Robert Francis QC was clear in his Inquiry report that the principal message of the NHS Constitution should be that patients and their safety come first. In <i>Hard Truths</i>, the Department of Health committed to strengthening the NHS Constitution to make this clearer for patients, staff and the public. To this end, The Government has launched a consultation into, amongst other things, refreshing the NHS Constitution to reflect the recommendations made by Sir Robert Francis QC. These are:</p> <ul style="list-style-type: none"> • duty of candour; • safe care and avoidable harm; • staff guidance, and; • a patient-centred NHS.

		<p>already been taken to improve staff performance and appraisal systems (as set out in the response to recommendation 7).</p> <p>NHS Employers will support NHS organisations in strengthening local policies on appraisals so that there is a clear link on the need for candour, openness and transparency in local appraisals and performance arrangements.</p>	
179	<p>'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.</p>	<p>Accepted.</p> <p>We understand the critical importance of fostering and sustaining an open culture in which concerns about care can be raised, investigated and acted upon without fear of retribution. Our policy is clear that any attempts to prevent individuals from speaking out in the public interest will not be tolerated. NHS guidance has been consistently clear that local policies should prohibit the inclusion of confidentiality clauses in contracts of employment and compromise agreements which seek to prevent an individual from making a disclosure in accordance with the Public Interest Disclosure Act (PIDA). We are, however, also aware that some confidentiality clauses that may make some people feel as though they are being 'gagged' even though they are not. Such clauses, although not illegal, may have what is known as a 'chilling effect' on some people. We now therefore require the inclusion of an explicit clause in the compromise agreement to make it absolutely clear to staff signing an agreement that they can make a disclosure in the public interest in accordance with PIDA, regardless of what other clauses may be included in the agreement.</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>
180	<p>Guidance and policies should be reviewed to ensure that they will lead to compliance with <i>Being Open</i>, the guidance published by the National Patient Safety Agency.</p>	<p>Accepted.</p> <p>As stated in recommendation 174, the intention is introduce an explicit duty of candour on providers as a Care Quality Commission registration requirement. The Department of Health will publish shortly draft regulations on a Statutory Duty of Candour during the autumn for further consultation. The Department of Health will ensure that advice such as the <i>Being Open</i> framework produced by the National Patient Safety Agency is considered as we consult on the new duty of candour.</p>	<p>As stated in the progress update to recommendation 174, the Department of Health has put in place a new statutory duty of candour as a requirement for registration with the Care Quality Commission that has applied to NHS organisations since November 2014 and will come into effect for other organisations from April 2015. The Department of Health has worked to ensure that the regulations take account of, and are congruent with, the <i>Being Open</i> framework produced by the National Patient Safety Agency.</p>
181	<p>A statutory obligation should be imposed to observe a duty of candour:</p> <ul style="list-style-type: none"> 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. <p>The provision of information in compliance with</p>	<p>Accepted in principle.</p> <p>As set out in recommendation 174, the Government will introduce an explicit duty of candour as a Care Quality Commission registration requirement. The duty would apply to health and adult social care providers of regulated activities. This duty will be enforced using the Care Quality Commission powers. The Care Quality Commission consulted on the potential introduction of a Duty of Candour in its document A new start – Consultation on changes to the way Care Quality Commission regulates, inspects and monitors care. Its consultation response, published in October 2013, showed respondents were strongly in favour of a statutory duty. As a mark of the Government's commitment to the duty of candour, the Care Bill puts a requirement on the Secretary of State to include a duty of candour in the requirements for registration with the Care Quality Commission. The Department of Health will consult on the regulations setting this duty which would require providers to inform people of the incident, provide an explanation, and where appropriate an apology. The Department will seek advice from experts on how to improve the reporting of patient safety incidents, including whether or not the threshold for the statutory duty of candour should include moderate harm. The final details will be set out in new regulations, which provide the flexibility to amend or vary the regulations over time as the new duty is established.</p> <p>As a further incentive for Trusts to promote a culture of openness across their organisation, the Government will consult on proposals about whether Trusts should reimburse a proportion or all of the NHS Litigation Authority's</p>	<p>The Department of Health s put in place a new statutory duty of candour as a requirement for registration with the Care Quality Commission. This has applied to NHS organisations since November 2014 and will come into effect for other organisations from April 2015. .</p> <p>As stated in the update to recommendation 175, eight of the UK professional regulators issued a joint statement on candour in October 2014 and the General Medical Council and the Nursing and Midwifery Council are consulting on joint draft explanatory guidance for the professional duty of candour.</p>

	<p>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.</p>	<p>compensation costs when they have not been open about a safety incident. Where the NHS Litigation Authority finds that a Trust has not been open with patients or their families about a patient safety incident which turns into a claim, it could have the discretion to reduce or remove that Trust's indemnity cover for that claim. The NHS Litigation Authority will continue to make compensation payments due to patients. Trusts who were not open with their patients could be required to reimburse the NHS Litigation Authority for a proportion or all of the payment.</p> <p>The Government agrees that the professional values of individual clinicians are critical in ensuring an open culture in which mistakes are reported, whether or not they cause actual harm. General Medical Council, Nursing and Midwifery Council and other professional regulators will be working to agree consistent approaches to candour and reporting of errors, including a common responsibility across doctors and nurses, and other health professions to be candid with patients when mistakes occur whether serious or not, and clear guidance that professionals who seek to obstruct others in raising concerns or being candid would be in breach of their professional responsibilities. The Department of Health will ask the Professional Standards Authority to advise and report on progress with this work. The professional regulators will develop new guidance to make it clear professionals' responsibility to report 'near misses' for errors that could have led to death or serious injury, as well as actual harm, at the earliest available opportunity and will review their professional codes of conduct to bring them into line with this guidance. The professional regulators will also review their guidance to panels taking decisions on professional misconduct to ensure they take proper account of whether or not professionals have raised concerns promptly.</p>	
182	<p>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</p>	<p>Accepted.</p> <p>Subject to the passage of the Care Bill, a new criminal offence will be introduced applicable to care providers that supply or publish certain types of information which is false or misleading, where that information is required to comply with a statutory or other legal obligation. The offence will allow for the prosecution of directors and senior individuals, where the offence has been committed with their consent or connivance or through their neglect, and a successful prosecution has been brought against the provider.</p> <p>This offence will give providers an additional incentive to ensure data and the information it provides are accurate. The offence will aid transparency and accountability in the provision of care so that regulators, commissioners and the public have a more accurate picture about a provider's performance. The offence will apply to those care providers that falsify certain types of management and performance information and fail to exercise due diligence. Providers that make a genuine administrative error would not be convicted, providing they have processes and procedures in place to demonstrate they took all reasonable steps and exercised due diligence.</p> <p>Our current intention is that regulations will limit the application of this offence in the first instance to providers of NHS funded secondary care and, more specifically, to the patient level information on outpatient, elective and accident and emergency activity that they are required to provide to the Health and Social Care Information Centre. However, we intend to test and confirm our thinking through further consultation before draft regulations are laid.</p>	<p>The Care Act 2014 sets out the framework of a criminal offence for a provider to supply or publish false or misleading information. The offence in the Act is very wide in its application, but can be limited via secondary legislation to apply to specific providers and information.</p> <p>The Care Act received Royal Assent in May 2014 and will implement the offence in the following way:</p> <ul style="list-style-type: none"> • extends to any information supplied, published or otherwise made available in response to a statutory or other legal requirement, and not just to information provided to a regulator or commissioner, subject to the information being specified in regulations; • is focused at an organisation level, whether corporate bodies or partnerships (referred to as "care providers"). It will only apply to Directors and other senior individuals where the offence is committed with their consent or connivance or through their neglect, and the provider organisation is also guilty of the offence; and • is a strict liability offence at care provider level. This means that the prosecution would not have to prove that there was intent to supply or publish false or misleading information on the part of the corporate body or partnership (whether dishonestly, knowingly or wilfully). <p>The offence will be specific to the patient level information on outpatient, elective and accident and emergency activity that providers of publicly funded NHS secondary care are required to provide to the Health and Social Care Information Centre. The offence will also be applied to Quality Accounts published by NHS Trusts. The Government intends to commence the regulations which set the scope of the offence in April 2015.</p>
183	<p>It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an</p>	<p>Not accepted, however we agree with the intention behind this recommendation.</p> <p>The duty of candour is a further drive towards openness and transparency. We have</p>	<p>The Secretary of State for Health commissioned Sir Robert Francis to carry out an independent policy review, called <i>Freedom to Speak Up</i>, in order to provide independent advice and recommendations on creating a more open and honest</p>

	<p>authorised or registered healthcare organisation:</p> <ul style="list-style-type: none"> • 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. 	<p>set out in the Care Bill that in future, as a registration requirement with the Care Quality Commission, providers must be open with patients about care failings. We are working with the General Medical Council, Nursing and Midwifery Council and other professional regulators to strengthen the references to candour in their work – including clear guidance that professionals who seek to obstruct others in raising concerns or being candid would be in breach of their professional responsibilities. Recommendation 181 outlines the approach, and along with the new duty itself should drive an open culture throughout organisations, including its staff. We do not believe an individual obstruction offence is necessary at this time, but will carefully watch the impact of this approach as the new duty evolves.</p> <p>In addition, in April, the Enterprise and Regulatory Reform Act 2013 strengthened the position of whistleblowers so that an individual now has the right to expect their employer to take reasonable steps to prevent them suffering detriment from a co-worker as a result of blowing the whistle.</p> <p>As the regulator of health and care, the Care Quality Commission is using staff surveys and the whistleblowing concerns it receives as part of the data in its new intelligent monitoring system. This data will guide the Care Quality Commission about which hospitals to inspect. Since September the Care Quality Commission's new inspection system includes discussions with hospitals about how they deal with, and handle, whistleblowers.</p> <p>The Government does not intend to criminalise untruthful statements to commissioners and regulators made by healthcare professionals. However, the Government has already introduced the false or misleading information offence into the Care Bill [see recommendation 182], which will allow for the prosecution of directors and senior individuals, where the offence has been committed with their consent or connivance or through their neglect, and a successful prosecution has been brought against the provider. This will include a fine and/or custodial sentence of up to two years for directors/senior individuals.</p> <p>There is an equivalent provision regarding consent or connivance, in relation to directors and senior individuals, in the Care Quality Commission legislation (Health and Social Care Act 2008) which applies to all registration requirements, including the duty of candour when it is introduced. In addition, professional regulators will be working to agree consistent approaches to candour and reporting of errors, including a common responsibility across the professions to be candid as set out in recommendation 181.</p>	<p>reporting culture in the NHS. The review was asked to identify measures to help to foster a culture of reporting and in future better protect people who do speak out about patient safety, as well as learning lessons from the existing culture in the NHS by listening to those who have experience to share, both positive and negative. The aim was to learn from other areas where safety is vital – such as aviation, nuclear power and the oil industry – about how to foster a culture in which it is simply the norm to flag up problems, risks and mistakes as they occur and in which everyone – from the CEO to the cleaners – does the right thing without hesitation and without fear of comeback.</p> <p>The recommendations of the review were published on 11 February 2015. The Government and all the national NHS bodies welcome the recommendations of the review and the principles that underpin them.</p>
184	<p>Observance of the duty should be policed by the Care Quality Commission, which should have powers to prosecute in the last resort 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.</p>	<p>Accepted.</p> <p>This is accepted in respect of the statutory duty of candour. This new duty will be a requirement for registration with the Care Quality Commission. In line with other registration requirements, Care Quality Commission will monitor compliance with the duty of candour and has a range of enforcement powers it can use where providers fail to meet the registration requirement.</p>	<p>The duty of candour is a legal requirement and Care Quality Commission will be able to take enforcement action when it finds breaches. The duty of candour has applied to NHS organisations from November 2014 and will apply to all other organisations from April 2015. Where an unintended or unexpected incident appears to have resulted in, or could still result in, significant harm to a specific service user, the regulations prescribe a formal set of notification procedures that the provider must follow when informing the service user (or their representative) of that harm. Providers must notify the service user about incidents where significant harm has occurred or could have occurred, give an apology and follow up the incident in writing. Failure to comply with the duty of candour registration regulation requirement could result in prosecution or, in the worst cases, an organisation could have their Care Quality Commission registration removed and so effectively be shut down.</p> <p>The Care Quality Commission's 'safety' domain that helps guide its inspections, looks in detail at the quality of reporting, investigating and most importantly learning from things that go wrong, and together with the 'well-led' domain will assess how well the new statutory Duty of Candour is being introduced and</p>

			<p>supported.</p> <p><i>Hard Truths</i> proposed that where the NHS Litigation Authority finds that a Trust has breached the statutory duty of candour about a patient safety incident which results in a claim, the NHS Litigation Authority could have the discretion to reduce or remove that Trust's indemnity cover for that claim. This would serve as a further incentive for organisations to develop a culture of candour, transparency and honesty. The Government plans to consult on how this could be taken forward. The NHS Litigation Authority has also issued guidance to the NHS on Saying Sorry and have reiterated that to support a duty of candour an apology is not an admission of guilt but the right thing to do.</p>
185	<p>There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires:</p> <ul style="list-style-type: none"> • Selection of recruits to the profession who evidence the: • Possession of the appropriate values, attitudes and behaviours; • Ability and motivation to enable them to put the welfare of others above their own interest; • Drive to maintain, develop and improve their own standards and abilities; • Intellectual achievements to enable them to acquire through training the necessary technical skills: • Training and experience in delivery of compassionate care; • Leadership which constantly reinforces values and standards of compassionate care; • Involvement in, and responsibility for, the planning and delivery of compassionate care; • Constant support and incentivisation which values nurses and the work they do through: • Recognition of achievement; • Regular, comprehensive feedback on performance and concerns; • Encouraging them to report concerns and to give priority to patient well-being. 	<p>Accepted.</p> <p>Building on the actions set out in the Government's initial response to the Inquiry, <i>Patients First and Foremost</i>, and <i>Compassion in Practice</i>, the nursing vision and strategy for England, various actions are underway to address this recommendation.</p> <p>The Nursing and Midwifery Council has introduced new education standards. These require students to be tested for aptitude in literacy, numeracy and communication skills, and assessed as to health and good character on admission to programmes. Students must also pass all assessments at every progression point before they complete their programmes and be assessed for good health and good character as to their fitness for award and fitness to practice. Education programmes are half theory, half practice, and education and training takes place as a partnership between a university and practice environment. Students must meet all theory and all practice requirements to complete a programme, and there is no facility to compensate for poor performance in one area with strong performance in the other. The first nurses to have followed programmes approved against these new standards will commence practice in 2014.</p> <p>The NHS Leadership Academy's new leadership development programmes – underpinned by a revised leadership model – will focus on values, attitudes and behaviours and will see a range of NHS staff including doctors, allied health professionals, nurses, midwives, pharmacists and healthcare scientists learning in a multi-professional environment more conducive to prompting compassionate care. From preceptorship programmes through to programmes for those working at the most senior levels these high quality, accredited programmes put in place the training and development needed to address the challenges presented in this recommendation. Additionally successful completion of the programme and award will help in the recruitment and selection of suitably qualified nurses into more senior roles. NHS England is also working with Health Education England to embed the '6Cs' set out in <i>Compassion in Practice</i> in all nursing and midwifery university education and training. The Government will invest up to £40 million in nurse leadership at all stages of the nursing career.</p> <p>The Government's Mandate to Health Education England contained a requirement to ensure that selection into all new NHS funded training posts incorporates testing of values. NHS England is working with Health Education England and NHS Employers to support the introduction of value-based recruitment and appraisal for all registered or unregistered staff.</p> <p>We believe that placing a strong emphasis on values at the outset of training potential staff is vital to embed the principles of compassion and caring from the very beginning in those who will one day provide care to patients. It is essential that the staff of tomorrow are able to demonstrate not only academic and technical ability, but also that they have the values of kindness and compassion that are needed to care for patients in an emotionally demanding environment.</p>	<p>The Nursing and Midwifery Council has commenced the evaluation of their standards for pre-registration education for nurses and midwives. Central to the evaluation are questions about the effectiveness of standards in preparing nurses and midwives for their professional roles and responsibilities which include care, compassion and leadership. The Nursing and Midwifery Council is in the final stages of appointing an independent evaluation supplier and expect to publish the final report in September 2015. The interim findings will be shared with Health Education England to tie into the Shape of Caring Review, which will ensure high quality education and training is received by nurses and care assistants supporting high quality patient care. The outcomes of the evaluation will provide an evidence base for future reviews of their pre-registration standards for education so that they can, where necessary, enhance the UK standards for nurse and midwifery competence and education.</p> <p>The NHS Leadership Academy's new healthcare leadership model for the NHS was published in November 2013. The model is applicable to all NHS staff roles and builds on the earlier Leadership framework, and is comprised of nine 'leadership dimensions' which set out the qualities that should be demonstrated by leaders at all levels.</p> <p>The initial group of 150 aspiring nurse students have now completed up to one year working as healthcare assistants, gaining experience of caring prior to starting their studies. In April 2014, Health Education England established a second set of pilots with 90 aspiring student nurses beginning work as healthcare assistants. A group of 160 healthcare assistants began work in September 2014, with between approximately 250 and 400 further participants expected by Spring 2015.</p>

		<p>One of the most important things for securing compassionate care is making sure that the right staff, with the right capabilities, are recruited into posts involving direct care at the outset.</p> <p>In <i>Patients First and Foremost</i>, the Government committed to a pilot programme, whereby every student who seeks NHS funding for nursing degrees will serve up to a year as a healthcare assistant.</p> <p>The pilot is an opportunity for aspiring nurse students to get real, paid caring experience for up to one year as a healthcare assistant before entering undergraduate nursing education, to see if nursing is right for them and they are right for nursing.</p> <p>In September 2013, Health Education England established the first set of pilots, and approximately 150 aspiring student nurses began working as healthcare assistants. Health Education England is looking to introduce further pilots in Spring 2014. On completion the pilot will be evaluated to see how pre-degree care experience could be rolled out in an affordable and cost-neutral way, so that everybody who wants to train to be a nurse is able to get caring experience before they start their studies. The evaluation results of the pilot scheme will need to be considered in the context of the Nursing and Midwifery Council's 2010 pre-registration nursing standards and their application across the four countries of the United Kingdom.</p> <p>We believe that students will enter their nursing degree course with increased confidence that this is the career for them, along with a genuine and demonstrated aptitude for caring. In addition, all nursing degree programmes last at least three years and require that 50 per cent of time is spent in practice learning and 50 per cent in academic study. The first progression point cannot be passed unless the student undertakes a period of practice learning and assessment, and so nursing students will continue to gain experience in care environments throughout their studies.</p> <p>Alongside this, work is on-going to make a career in nursing more accessible for those staff who already give care, as set out in the Mandate to Health Education England.</p>	
186	<p>Nursing training should be reviewed so that sufficient practical elements are incorporated to ensure that a consistent standard is achieved by all trainees throughout the country. This requires national standards.</p>	<p>The Nursing and Midwifery Council published new standards for all pre-registration nursing programmes in 2010 which must be followed at all the universities they approve to run nursing courses. The previous 2004 standards were updated and strengthened as a result of the findings of the first Francis Inquiry and emerging evidence at that time. The first nurses to have followed programmes approved against the new standards will commence practice in 2014.</p> <p>These national pre-registration nursing standards include the content and practice/study time ratios required by European Directive. All the nursing programmes last at least three years and require 50 per cent of time to be spent in practice learning and 50 per cent in academic study. The first progression point cannot be passed unless the student undertakes a period of practice learning and assessment. Currently formal learning and supervised work as a healthcare support worker can be counted through accredited prior learning routes.</p> <p>The Nursing and Midwifery Council will be undertaking a full evaluation of these new education standards, commencing in 2014, and will have particular regard to these issues of caring and compassion. This will give a proper evidence base for any further revisions to these new standards, and the Nursing and Midwifery Council will consider this recommendation in parallel with their evaluation.</p> <p>Although the overarching national standards are in place, the detail of the nursing</p>	<p>The Nursing and Midwifery Council has commenced the evaluation of their standards for pre-registration education for nurses and midwives. Central to the evaluation are questions about the effectiveness of standards in preparing nurses and midwives for their professional roles and responsibilities which include care, compassion and leadership. The Nursing and Midwifery Council is in the final stages of appointing an independent evaluation supplier will proactively share any interim findings with Health Education England to tie into the Shape of Caring Review. The Nursing and Midwifery Council's final report should be available in September 2015.</p> <p>The outcomes of the evaluation will provide an evidence base for future reviews of their pre registration standards for education so that they can, where necessary, enhance the UK standards for nurse and midwifery competence and education.</p>

		<p>curriculum is dynamic. Employers, service providers and universities are now brought together in Local Education and Training Boards, as part of the Health Education England system, to ensure all NHS funded courses are fit for purpose and reflect service needs. We expect this new part of the system to recognise the importance of <i>Compassion in Practice</i>, the vision and strategy for nursing in England and the values and behaviours it describes in the '6Cs' to be part of the local review of courses and incorporated into the detailed undergraduate nursing curriculum.</p> <p>Health Education England and the Nursing and Midwifery Council will continue to collaborate on ensuring the undergraduate nursing curriculum meets patient need</p>	
187	<p>There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care. Satisfactory completion of this direct care experience should be a pre-condition to continuation in nurse training. Supervised work of this type as a healthcare support worker should be allowed to count as an equivalent. An alternative would be to require candidates for qualification for registration to undertake a minimum period of work in an approved healthcare support worker post involving the delivery of such care.</p>	<p>In its initial response to The Inquiry, <i>Patients First and Foremost</i>, the Government committed to a pilot programme, whereby every student who seeks NHS funding for nursing degrees will serve up to a year as a healthcare assistant. The pilot is an opportunity for aspiring nurse students to get real, paid caring experience for up to one year as a healthcare assistant before entering undergraduate nursing education, to see if nursing is right for them and they are right for nursing.</p> <p>In September 2013, Health Education England established the first set of pilots, and approximately 150 aspiring student nurses began working as healthcare assistants. Health Education England is looking to introduce further pilots in Spring 2014. On completion the pilot will be evaluated to see how pre-degree care experience could be rolled out in an affordable and cost-neutral way, so that everybody who wants to train to be a nurse is able to get caring experience before they start their studies. The evaluation results of the pilot scheme will need to be considered in the context of the Nursing and Midwifery Council's 2010 pre-registration nursing standards and their application across the four countries of the United Kingdom.</p> <p>We believe that students will enter their nursing degree course with increased confidence that this is the career for them, along with a genuine and demonstrated aptitude for caring. In addition, all nursing degree programmes last at least three years and require that 50 per cent of time is spent in practice learning and 50 per cent in academic study. The first progression point cannot be passed unless the student undertakes a period of practice learning and assessment, and so nursing students will continue to gain experience in care environments throughout their studies.</p> <p>Alongside this, work is on-going to make a career in nursing more accessible for those staff who already give care, as set out in the Government's Mandate to Health Education England.</p>	<p>In September 2013, Health Education England established the first set of pilots, and approximately 150 aspiring student nurses have now completed up to one year working as healthcare assistants, gaining experience of caring prior to starting their studies. In April 2014, a further 90 aspiring student nurses began work, with a further 160 healthcare assistants entering the programme in September 2014. Between approximately 250 and 400 further participants are expected by Spring 2015.</p>
188	<p>The Nursing and Midwifery Council working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates' attitudes towards caring, compassion and other necessary professional values.</p>	<p>Accepted in principle.</p> <p>The Government's Mandate to Health Education England contained a requirement to ensure that selection into all new NHS funded training posts incorporates testing of values. In addition, NHS England is working with Health Education England and NHS Employers to support the introduction of values-based recruitment and appraisal for all registered and unregistered staff.</p> <p>We believe that placing a strong emphasis on values at the outset of training potential staff is vital to embed the principles of compassion and caring from the very beginning in those who will one day provide care to patients. It is essential that the staff of tomorrow are able to demonstrate not only academic and technical ability, but also that they have the values of kindness and compassion that are needed to care for patients in an emotionally demanding environment.</p> <p>The Nursing and Midwifery Council introduced new education standards in 2010. These require students to be tested for aptitude in literacy, numeracy and</p>	<p>NHS Employers is working on a Values Based Recruitment project in partnership with Health Education England, to ensure that staff who are recruited into the NHS are recruited for values, to deliver the best possible care for patients. This includes a number of resources to support employers including good practice case studies and a model policy. Further resources including case studies and podcasts will continue to be developed during this financial year.</p> <p>The Nursing and Midwifery Council has commenced the evaluation of their standards for pre-registration education for nurses and midwives. Central to the evaluation are questions about the effectiveness of standards in preparing nurses and midwives for their professional roles and responsibilities which include care, compassion and leadership. The Nursing and Midwifery Council is in the final stages of appointing an independent evaluation supplier and they will proactively share any interim findings with Health Education England to tie into the Shape of Caring Review. The Nursing and Midwifery Council's final report should be available in September 2015.</p> <p>The outcomes of the evaluation will provide an evidence base for future reviews of their pre-registration standards for education so that they can, where</p>

		<p>communication skills and assessed as to health and good character on admission to programmes. Students must also pass all assessments at every progression point before they complete their programmes and be assessed for good health and good character as to their fitness for award and fitness to practice. Education programmes are half theory, half practice, and education and training takes place as a partnership between a university and practice environment. Students must meet all theory and all practice requirements to complete a programme, and there is no facility to compensate for poor performance in one area with strong performance in the other.</p> <p>The Nursing and Midwifery Council's standards for competence reinforce this, identifying the knowledge, skills and attitudes students must acquire by the end of their programme. For example, students must 'practise in a holistic, non-judgmental, caring and sensitive manner that avoids assumptions, supports social inclusion, recognises and respects individual choice and acknowledges diversity'.</p> <p>The Nursing and Midwifery Council has committed to undertaking a full evaluation of its new education standards, commencing in 2014, and will have particular regard to issues of caring and compassion. This will give the Nursing and Midwifery Council an evidence base for any further revisions to these new standards, including the need for an aptitude test.</p>	necessary, enhance the UK standards for nurse and midwifery competence and education.
189	The Nursing and Midwifery Council and other professional and academic bodies should work towards a common qualification assessment/examination.	<p>Accepted in principle.</p> <p>The Nursing and Midwifery Council is responsible for setting the UK-wide standards for all pre-registration nursing and midwifery education. These standards underpin all pre- registration nursing and midwifery education so that education programmes are comparable, and all nurses and midwives must meet the same standards. The Nursing and Midwifery Council set new standards for pre-registration nursing education in 2010. The standards require students to be tested for aptitude in literacy, numeracy and communication skills, and assessed as to health and good character on admission to programmes. Students must also pass all assessments at every progression point before they complete their programmes, and be assessed for good health and good character as to their fitness for award and fitness to practice. Education programmes are half theory, half practice, and education and training takes place as a partnership between a university and practice environment. Students must meet all theory and all practice requirements to complete a programme, and there is no facility to compensate for poor performance in one area with strong performance in the other.</p> <p>The Nursing and Midwifery Council has committed to undertaking a full evaluation of its new education standards, commencing in 2014, and will have particular regard to issues of caring and compassion. This will give the Nursing and Midwifery Council an evidence base for any further revisions to these new standards.</p>	<p>The Nursing and Midwifery Council has commenced the evaluation of their standards for pre-registration education for nurses and midwives. Central to the evaluation are questions about the effectiveness of standards in preparing nurses and midwives for their professional roles and responsibilities which include care, compassion and leadership. The Nursing and Midwifery Council is in the final stages of appointing an independent evaluation supplier and they will proactively share any interim findings with Health Education England to tie into the Shape of Caring Review. The Nursing and Midwifery Council's final report should be available in September 2015.</p> <p>The outcomes of the evaluation will provide an evidence base for future reviews of their pre-registration standards for education so that they can, where necessary, enhance the UK standards for nurse and midwifery competence and education.</p>
190	There should be national training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of the fundamental aspects of compassionate care.	<p>Accepted in part.</p> <p>The Nursing and Midwifery Council already sets national standards for undergraduate degrees, but Health Education England and NHS England, in collaboration with the Nursing and Midwifery Council and the universities, will work closely together to ensure newly qualified nurses are competent at the point of registration.</p> <p>This collaboration is vital because the competence of nursing students is assessed not only in the classroom by the universities, but in clinical practice by mentors and assessors who are experienced, practising NHS nurses. NHS England should ensure that <i>Compassion in Practice</i>, the vision and strategy for nursing in England, and its behaviours and values expressed as the '6Cs', are used to assess student nurses during their</p>	To provide support to preceptorship, some Health Education England Local Education and Training Boards have developed Preceptorship Standards with their stakeholders to enable service providers to have a better understanding of what good preceptorship entails.

		<p>clinical placements. The importance of robust mentoring and assessing of student nurses will be endorsed by NHS England so that only student nurses who are competent pass their assessments and are consequently recommended for registration. The Nursing and Midwifery Council has put a system of 'sign off mentors' in place so that experienced NHS nurses sign off student nurses achievements in clinical practice, and NHS England needs to ensure that mentors are sufficiently supported to make difficult decisions and confidently fail a student if necessary.</p> <p>Competence at the point of registration needs to be enhanced in the first months of qualification by Health Education England, NHS England and employers giving appropriate support to newly qualified nurses. The established mechanism for this is through preceptorship, but Health Education England and NHS England will need to assure themselves that preceptorship programmes are systematically embedded and properly supported so that newly qualified nurses can grow in competence and confidence and effectively make the transition from being a student to a professional, practising registered nurse.</p>	
191	<p>Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.</p>	<p>Accepted.</p> <p>The Government's Mandate to Health Education England contained a requirement to ensure that selection into all new NHS-funded training posts incorporates testing of values-based recruitment. NHS England is working with Health Education England and NHS Employers to support the introduction of values-based recruitment and appraisal for all registered or unregistered staff.</p> <p>Placing a strong emphasis on values at the outset of training potential staff is vital to embed the principles of compassion and caring from the very beginning in those who will one day provide care to patients. It is essential that the staff of tomorrow are able to demonstrate not only academic and technical ability, but also that they have the values of kindness and compassion that are needed to care for patients in an emotionally demanding environment.</p> <p>Health Education England and Local Education and Training Boards (who are responsible for the education and training of NHS staff within 13 different regions in England), are working with employers and education providers to be responsible for the development of the future workforce. They also have a role to play to ensure that the current workforce is fit for purpose and able to provide care of the highest quality.</p> <p>As set out in its Mandate, Health Education England is committed to the introduction of values based recruitment for all students entering NHS-funded clinical education programmes and to also support such processes for recruitment into NHS employment.</p> <p>The three key objectives of Health Education England's national values-based recruitment programme focus on:</p> <ol style="list-style-type: none"> 1. recruiting for Values in Higher Education Institutions; 2. recruiting for Values in the NHS; and 3. evaluating the impact of Recruiting for Values. <p>Over the long term, Health Education England sees values-based recruitment as part of a wider programme to change attitudes and behaviours of NHS staff, enhancing their engagement and continuously improving healthcare for its patients.</p>	<p>With Health Education England, NHS Employers has developed a mapping tool to allow local organisations to map their values to those in the NHS Constitution. NHS Employers has also produced guidance for employers linking pay progression, appraisal and performance management. This includes a number of resources to support employers including good practice case studies and a model policy. Further resources including case studies and podcasts will continue to be developed during the year.</p> <p>NHS Employers is also leading the implementation of action area 6 of the Compassion in Practice implementation plan for the Chief Nursing Officer – this focuses on staff experience. Year one of this work has highlighted good practice in strengthening the delivery of the NHS Constitution pledges to staff and signposted employers to existing supporting resources. Discussions are underway to agree the content of the Year two programme which is likely to include the development of a mapping tool to link local values and the compassion in practise 6Cs.</p>

		<p>In addition, there is an on-going project to develop values-based recruitment tools for social care providers. This project, involving the National Skills Academy for Social Care, brings together a range of directly-targeted, free, easy-to-use tools that employers can use when recruiting staff, to assess candidates for appropriate social care values, as evidenced through their behaviours. These tools can sit alongside other tests around competencies and skills.</p> <p>The toolkit adapts materials that are already currently available and brings them together in a package, in the first instance to support employers in recruiting the right candidates for a career in care. There is also an option to extend the toolkit to assist potential candidates in deciding whether they are suitable to pursue a career in care.</p>	
192	<p>The Department of Health and the Nursing and Midwifery Council should introduce the concept of a Responsible Officer for nursing, appointed by and accountable to, the Nursing and Midwifery Council.</p>	<p>Accepted in principle.</p> <p>The aim of the recommendation, which is to have a role that is accountable for providing assurance to the Nursing and Midwifery Council that nurses are meeting professional standards and are keeping themselves up-to-date and fit to practise, is best achieved through the introduction of nursing revalidation. Unlike the General Medical Council's model of revalidation, the Nursing and Midwifery Council does not consider that this model of revalidation requires a Responsible Officer role.</p> <p>The Nursing and Midwifery Council has committed to introducing a proportionate and effective model of revalidation, which is affordable and value for money, to enhance public protection. Subject to public consultation, the proposed model would require evidence that the nurse or midwife is fit to practise. Under the current proposals, the Nursing and Midwifery Council Code and standards would be reviewed and revised to ensure they would be compatible with revalidation, and guidance for revalidation would also be developed.</p> <p>NHS Employers will lead work on ensuring that there is a clear link between the values in the <i>NHS Constitution</i>, the vision and strategy for nursing in England, its values and behaviours as set out in the '6Cs', and the organisation's own local values. Building on this, the Department of Health will commission NHS Employers to help local organisations develop and improve value based appraisal and performance management. This will also support the actions set out in <i>Compassion in Practice</i>.</p>	<p>In February 2013, the Nursing and Midwifery Council began a UK-wide programme of engagement on revalidation and has held two national consultations. The first ran from January to March 2014 and focused on the proposed model of revalidation The second, which ran from May to August 2014, included a draft revised Code intended to address the issues raised by the Francis reports into failings at Mid Staffordshire NHS Foundation Trust. These include, for example, putting patients first (including a greater emphasis on providing the fundamentals of care, hydration and nutrition); dealing with complaints; raising concerns ('whistle-blowing'); the professional 'duty of candour'; and leadership, delegation and teamworking.</p> <p>The Nursing and Midwifery Council will test the resulting revalidation model in a pilot during 2015 and full implementation of the model is planned to commence by the end of 2015. The Nursing and Midwifery Council has established an oversight board that will drive forward the planning and confirm that the UK is sufficiently ready for implementation.</p> <p>With Health Education England, NHS Employers has developed a mapping tool to allow local organisations to map their values to those in the NHS Constitution. NHS Employers has also produced guidance for employers linking pay progression, appraisal and performance management. This includes a number of resources to support employers including good practice case studies and a model policy. Further resources including case studies and podcasts will continue to be developed during the year.</p>
193	<p>Without introducing a revalidation scheme immediately, the Nursing and Midwifery Council should introduce common minimum standards for appraisal and support with which responsible officers would be obliged to comply. They could be required to report to the Nursing and Midwifery Council on their performance on a regular basis.</p>	<p>Accepted in principle.</p> <p>In advance of the introduction of revalidation by the Nursing and Midwifery Council, NHS Employers will:</p> <ul style="list-style-type: none"> • support NHS organisations in ensuring they have a clear link between the values in the NHS Constitution and their own local values • support NHS organisations in developing and improving values based appraisal and performance management having taken steps to improve performance appraisals for the 1.1 million staff on Agenda for Change as set out in recommendation 7 • encourage NHS organisations to make the necessary links with the work the Nursing and Midwifery Council is leading on revalidation as they develop new local performance and appraisal arrangements. <p>The Nursing and Midwifery Council has committed to introducing a proportionate and effective model of revalidation, which is affordable and value for money, to enhance public protection. Subject to public consultation, the proposed model would</p>	<p>In February 2013, the Nursing and Midwifery Council began a UK-wide programme of engagement on revalidation and has held two national consultations. The first ran from January to March 2014 and focused on the proposed model of revalidation The second, which ran from May to August 2014, included a draft revised Code intended to address the issues raised by the Francis reports into failings at Mid Staffordshire NHS Foundation Trust. These include, for example, putting patients first (including a greater emphasis on providing the fundamentals of care, hydration and nutrition); dealing with complaints; raising concerns ('whistle-blowing'); the professional 'duty of candour'; and leadership, delegation and teamworking.</p> <p>The Nursing and Midwifery Council will test the resulting revalidation model in a pilot during 2015 and full implementation of the model is planned to commence by the end of 2015. The Nursing and Midwifery Council has established an oversight board that will drive forward the planning and confirm that the UK is sufficiently ready for implementation.</p> <p>With Health Education England, NHS Employers has developed a mapping tool to allow local organisations to map their values to those in the NHS Constitution.</p>

		<p>require evidence that the nurse or midwife is fit to practise. Under the current proposals, the Nursing and Midwifery Council Code and standards would be reviewed and revised to ensure they would be compatible with revalidation, and guidance for revalidation would also be developed.</p>	<p>NHS Employers has also produced guidance for employers linking pay progression, appraisal and performance management. This includes a number of resources to support employers including good practice case studies and a model policy. Further resources including case studies and podcasts will continue to be developed during the year.</p>
194	<p>As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidence by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.</p>	<p>Accepted in principle.</p> <p>We consider that the aim of the recommendation, which is to have a role that is accountable for providing assurance to the Nursing and Midwifery Council that nurses can show they are keeping themselves up-to-date and fit to practise, is best achieved through the introduction of nursing revalidation.</p> <p>The Inquiry also recommended that independent of the development of nurse revalidation, the Nursing and Midwifery Council could establish minimum standards for appraisal and support, which could be overseen by Responsible Officers appointed and accountable to the Nursing and Midwifery Council.</p> <p>The Nursing and Midwifery Council has committed to introducing a proportionate and effective model of revalidation, which is affordable and value for money, to enhance public protection. Subject to public consultation, the proposed model would require evidence that the nurse or midwife is fit to practise. Under the current proposals, the Nursing and Midwifery Council Code and standards would be reviewed and revised to ensure they would be compatible with revalidation, and guidance for revalidation would also be developed.</p> <p>In addition, before the introduction of revalidation by the Nursing and Midwifery Council, NHS Employers will:</p> <ul style="list-style-type: none"> • support NHS organisations in ensuring they have a clear link between the values in the NHS Constitution and their own local values • support NHS organisations in developing and improving values based appraisal and performance management having taken steps to improve performance appraisals for the 1.1 million staff on Agenda for Change as set out in recommendation 7 • encourage NHS organisations to make the necessary links with the work the Nursing and Midwifery Council is leading on revalidation as they develop new local performance and appraisal arrangements. <p>High performing staff can improve outcomes for patients. The Government strongly encourages employers to use the full flexibilities in existing pay contracts so that pay progression is linked to quality of care, not time served. NHS Employers will support this by working with the service on new model performance frameworks, which will place greater emphasis on the quality of care, including the important NHS values of compassion, dignity</p>	<p>In February 2013, the Nursing and Midwifery Council began a UK-wide programme of engagement on revalidation and has held two national consultations. The first ran from January to March 2014 and focused on the proposed model of revalidation. The second, which ran from May to August 2014, included a draft revised Code intended to address the issues raised by the Francis reports into failings at Mid Staffordshire NHS Foundation Trust. These include, for example, putting patients first (including a greater emphasis on providing the fundamentals of care, hydration and nutrition); dealing with complaints; raising concerns ('whistle-blowing'); the professional 'duty of candour'; and leadership, delegation and teamworking.</p> <p>The Nursing and Midwifery Council will test the resulting revalidation model in a pilot during 2015 and full implementation of the model is planned to commence by the end of 2015. The Nursing and Midwifery Council has established an oversight board that will drive forward the planning and confirm that the UK is sufficiently ready for implementation.</p> <p>With Health Education England, NHS Employers has developed a mapping tool to allow local organisations to map their values to those in the NHS Constitution. NHS Employers has also produced guidance for employers linking pay progression, appraisal and performance management. This includes a number of resources to support employers including good practice case studies and a model policy. Further resources including case studies and podcasts will continue to be developed during the year.</p>
195	<p>Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the</p>	<p>Accepted in principle.</p> <p>There needs to be local flexibility in delivering nursing care, so the Government are not mandating that ward nurse managers must operate solely in a supervisory capacity. However, in the initial Government response to The Inquiry, <i>Patients First and Foremost</i>, the Department of Health gave strong support to supervisory roles for Ward Managers (including Sister, Charge Nurse and Team Leader) in delivering oversight to all aspects of care on a ward and in a community, from cleanliness to allocation of staff. Nurse leadership and visibility at ward level provided by a Ward Manager is also important to the delivery of safe, high-quality care to patients.</p>	<p>The Royal College of Nursing has commissioned the University of Warwick to undertake a review of supervisory status in two acute trusts. The report of this review is due shortly.</p> <p>The project seeks to evaluate the change to supervisory ward sisters in two hospitals in the West Midlands. This change means the ward sister is now extra to establishment numbers and crucially has a supervisory role, being visible and accessible in the clinical area; working alongside the team; monitoring and providing feedback on standards and outcomes and creating a culture to enable person centred, safe and effective care. Data has been collected from individual ward sisters through the use of face-to-face interviews to explore how these changes have been perceived by the ward sisters themselves, what they hoped</p>

	<p>team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.</p>	<p>Having sufficient nurses trained and with the capacity to ensure the delivery of safe, patient focused care is currently a core standard requirement of the Care Quality Commission. Nurse leadership is a core element of <i>Compassion in Practice</i>, the vision and strategy for nursing in England.</p> <p>Key action areas include:</p> <ul style="list-style-type: none"> • using feedback to improve the reported experiences of patients; • identifying strong patient experience measures that can be used between settings and sectors; • a new leadership programme for ward managers, team leaders and nursing directors based on values and behaviours of the '6Cs' of <i>Compassion in Practice</i>; • providers reviewing options for introducing ward managers, team leaders and nursing directors based on values and behaviours of the '6Cs'; • providers reviewing supervisory status for ward managers and team leaders; • strategies to secure meaningful staff engagement; and • commissioners to ensure locally agreed targets to deliver high quality appraisals for their staff <p>Some Directors of Nursing are already achieving this or have plans and timetables in place to deliver it. Having supervisory leaders should be evaluated locally so that benefits can be demonstrated and shared.</p> <p>The NHS Leadership Academy 'offer' includes leadership programmes for frontline staff – including nurses. We have already taken steps to improve staff performance and appraisal systems as set out in our response to recommendation 7.</p>	<p>to achieve in moving into a supervisory role, and how they have evaluated whether the change has been successful in terms of patient care. In addition to collecting information from individual ward sisters the project team has interviewed senior nursing managers and the wider clinical team to explore their perceptions of the move to supervisory ward sister status.</p> <p>The final report of the study will be disseminated through publications, networking and conferences.</p> <p>NHS England is considering whether further work to assess the impact of supervisory nurses would be helpful to build on this study.</p> <p>The Social Partnership Forum produced guidance on staff engagement and partnership working and highlights areas of excellence in NHS organisations where management and trade union representatives work together effectively to identify and resolve issues. The need for this guidance was indicated in Hard Truths and builds on the six key messages developed by the forum to support the development of the values, culture and working environment in the NHS that would best ensure that patients receive safe, effective and compassionate care.</p>
196	<p>The Knowledge and Skills Framework should be reviewed with a view to giving explicit recognition to nurses' demonstrations of commitment to patient care and, in particular, to the priority to be accorded to dignity and respect, and their acquisition of leadership skills.</p>	<p>Accepted.</p> <p>Employers have the freedom to use the Knowledge and Skills Framework to develop their own local arrangements to ensure that dignity, respect and leadership is fully reflected in staff training and development and that capability, learning and development is part of local appraisal systems. This is made clear in the national Agenda for Change agreement which links pay progression more strongly to performance from March 2013, for more than 1.1 million NHS staff. NHS Employers are already working hard to help employers realise the benefits of the new national agreement on performance.</p> <p>The Department of Health will commission NHS Employers to encourage NHS organisations to strengthen their local knowledge and skills frameworks so that there is a clear line of sight between the <i>NHS Constitution</i>, the values and behaviours set out in the '6Cs' of <i>Compassion in Practice</i>, the vision and strategy for nursing in England, and local values, performance and appraisal systems.</p> <p>In addition, the Nursing and Midwifery Council's standards for competence require nurses to demonstrate their potential to develop management and leadership skills during their period of preceptorship after registration and beyond. This means that the public can trust the newly registered nurse to be an</p>	<p>With Health Education England, NHS Employers has developed a mapping tool to allow local organisations to map their values to those in the NHS Constitution. NHS Employers has also produced guidance for employers linking pay progression, appraisal and performance management to values and commitment to patient care. This includes a number of resources to support employers including good practice case studies and a model policy. Further resources including case studies and podcasts will continue to be developed during the year.</p>

		<p>autonomous and confident member of the multi-disciplinary or multi-agency team, and to inspire confidence in others. Nurses can then become more involved and responsible for the planning and delivery of care and improving future services. NHS Employers will encourage NHS organisations to make the necessary links with the work the Nursing and Midwifery Council is leading on revalidation as they develop new local performance and appraisal arrangements.</p>	
197	<p>Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff.</p>	<p>Accepted in part.</p> <p>Healthcare organisations have a responsibility to ensure that their staff and teams are appropriately trained and continuously developed: having properly trained staff is one of the requirements they have to meet to register with the Care Quality Commission. The NHS Leadership Academy core programmes will provide a structured and robust leadership development education from entry level to executive level. Focused on leadership for compassionate and effective care, the programmes will provide development on the skills, knowledge, behaviours and attitudes needed at every level to create a climate for staff that puts the patient first.</p> <p>Action areas under <i>Compassion in Practice</i>, the vision and strategy for nursing in England, include:</p> <ul style="list-style-type: none"> • new leadership programme for ward managers, team leaders and nursing directors based on values and behaviours of the '6Cs' of <i>Compassion in Practice</i> (care, compassion, courage, communication, competence, commitment); • providers to review options for introducing ward managers, team leaders and nursing directors based on values and behaviours of the '6Cs'; • commissioning leadership role (build into Action Area 4 in <i>Compassion in Practice</i>); and • contracts to address the percentage of staff who have accessed leadership development. <p>Arrangements for training are primarily the responsibility of providers, but when commissioners deem it is necessary, in order to ensure the delivery of services by staff with the right skills, they can set training requirements in their contracts with providers.</p> <p>The Nursing and Midwifery Council published new standards for all pre-registration nursing programmes in 2010 which must be followed at all the universities they approve to run nursing courses. The previous 2004 standards were updated and strengthened as a result of the findings of the first Francis Inquiry and emerging evidence at that time. The first nurses to have followed programmes approved against these new standards will commence practice in 2014.</p> <p>The Nursing and Midwifery Council will be undertaking a full evaluation of these new education standards, commencing in 2014, and will have particular regard to the issues of caring and compassion. This will give a proper evidence base for any further revisions to these new standards, and the Nursing and Midwifery Council will consider this recommendation in parallel with their evaluation.</p> <p>Although the overarching national standards are in place, the detail of the nursing curriculum is dynamic. Employers, service providers and universities are now brought together in Local Education and Training Boards, as part of the Health</p>	<p>The Nursing and Midwifery Council has commenced the evaluation of their standards for pre-registration education for nurses and midwives. Central to the evaluation are questions about the effectiveness of standards in preparing nurses and midwives for their professional roles and responsibilities which include care, compassion and leadership.</p> <p>The Nursing and Midwifery Council has appointed IFF Research to undertake the independent evaluation of pre-registration education for nurses and midwives. They are expected to submit their interim report to the Nursing and Midwifery Council in February 2015 at which point the findings will be shared with Health Education England. The Nursing and Midwifery Council's final report should be available by September 2015.</p> <p>The outcomes of the evaluation will provide an evidence base for future reviews of their pre-registration standards for education so that they can, where necessary, enhance the UK standards for nurse and midwifery competence and education.</p>

		<p>Education England system, to ensure all NHS funded courses are fit for purpose and reflect service needs. We expect this new part of the system to recognise the importance of <i>Compassion in Practice</i> and the values and behaviours it describes in the '6Cs', to be part of the local review of courses and incorporated into the detailed undergraduate nursing curriculum. The Department of Health will commission NHS Employers to encourage NHS organisations to strengthen their local knowledge and skills frameworks so that there is a clear line of sight between the NHS Constitution, the values and behaviours set out in the 6Cs of <i>Compassion in Practice</i>, the vision and strategy for nursing in England, and local values, performance and appraisal systems.</p> <p>Health Education England and the Nursing and Midwifery Council will continue to collaborate on ensuring the undergraduate nursing curriculum meets patient need.</p>	
198	<p>Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust methodology, such as the 'cultural barometer'.</p>	<p>Accepted.</p> <p>Both teams and organisations should develop ways to measure their cultural health, and act on these measures to improve. Cultural health is a matter for all staff groups; everybody who works in the health and care system is integral to improving and maintaining good cultural health. Many tools and methods are available and the Department of Health and other arm's length bodies are promoting these. For example, the Cultural Barometer, which was highlighted as a case study in the Government's initial response to The Inquiry, <i>Patients First and Foremost</i>, is being developed and piloted. The National Nursing Research Unit at Kings College London are evaluating the pilot and are expected to publish their report in November 2013. NHS England supports the use of tools such as the cultural barometer and real time staff experience feedback. The friends and family test for staff will be rolled out from April 2014.</p> <p>The Chief Nursing Officer is providing leadership through <i>Compassion in Practice</i>, the vision and strategy for nursing in England. Key action areas include:</p> <ul style="list-style-type: none"> • developing a set of tools that enable organisations to measure their culture; • providers undertaking a review of their organisational culture and publish the results; • reviewing implementation of the cultural barometer once pilots have taken place; • strategies to secure meaningful staff engagement; • commissioning leadership role (build into Action Area 4 in <i>Compassion in Practice</i>); and • commissioning an approach to ensure that staff feedback is being used to develop cultural health of front-line staff. <p>95. <i>Patients first and foremost – The Initial Government Response to the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry</i>, published 26 March 2013</p>	<p>Promoting positive and learning cultures remains critical to supporting service improvement.</p> <p>The Staff Friends and Family Test was introduced in April 2014. It is a feedback tool for staff, predominantly for local improvement work. It consists of two questions (with options to give free text feedback for each) through which organisations can take a temperature check of how staff are feeling. It is a quicker feedback mechanism than the existing NHS annual staff survey, and will help staff to voice their concerns (on a regular basis if they wish to) and help organisations to respond.</p> <p>Following the first pilot phase of the cultural barometer by King's College London, further work has taken place in two community and mental health sites to develop the tool further. Piloting will be complete by the end of the year and work is now underway to consider how best to make the barometer accessible and enable uptake. Further information on the barometer is available online.</p> <p>The Social Partnership Forum produced guidance on staff engagement and partnership working and highlights areas of excellence in NHS organisations where management and trade union representatives work together effectively to identify and resolve issues. The need for this guidance was indicated in <i>Hard Truths</i> and builds on the six key messages developed by the forum to support the development of the values, culture and working environment in the NHS that would best ensure that patients receive safe, effective and compassionate care.</p>
199	<p>Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated</p>	<p>Accepted.</p> <p>The Secretary of State for Health announced his support for patients having a named nurse in July 2013 and we are working with NHS England to support the delivery of this aim.</p>	<p>The Academy of Royal Colleges published <i>Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients</i> in June 2014. This provides guidance on how responsible clinicians and named nurses can be implemented in practice.</p>

	<p>patient.</p>	<p>As The Inquiry made clear, organisations can take local action on this issue, and we are pleased that some organisations, such as University College London Hospitals NHS Foundation Trust, already have a system of named nurses. Where named nurses have been implemented, this should be evaluated so that lessons can be learnt and good practice shared.</p> <p>At a seminar hosted by the Academy of Medical Royal Colleges on 25 September 2013, it was clear there is professional consensus around the issue of named clinicians, and the Academy is leading work to take this forward. The Academy will produce key principles with worked examples on how this can be implemented in a way that sustains professional support.</p>	
200	<p>Consideration should be given to the creation of a status of Registered Older Person's Nurse.</p>	<p>Accepted in part.</p> <p>The Department and its system partners have considered this recommendation and feel there are better ways of improving nursing care for older people. Caring for older people is core to the job of the vast majority of nurses working in wards throughout hospitals and across community settings. We will strengthen the focus on the complex physical and emotional needs of frail older people throughout nurse training to ensure that older people needing nursing care will benefit from a nursing workforce that is trained to deal with their needs.</p> <p>Many older people in hospitals are under the care of specialist teams (for example orthopaedics or cancer services) and require nurses to have those specialist skills. Additionally care of those older people who are frail, with many conditions, can take place in their own home and care homes as well as in hospitals. All registered nurses at the point of qualification need to be competent in managing and implementing care for older people. As a nurse's career progresses we need to ensure they have the opportunity to specialise in the care of older people. In doing so, we need to ensure they have the right skills – not just their clinical expertise but also their decision-making and judgement skills, so that they can help navigate older people through the complex systems of health and social care. To do this they need to build from the firm foundation of their undergraduate experience to develop their expertise at each stage of their career. This is why we are proposing to offer access to practical, continuous professional development and have a clear and rewarding career path from novice to expert.</p> <p>The Government has asked Health Education England, as part of its Mandate for 2013-2015, to work with Higher Education Institutions to review the content of pre-registration nurse education to ensure all new nurses have the skills to work with the large numbers of older people being treated in the healthcare system. Furthermore Health Education England, working with the Chief Nursing Officer, the Director of Nursing at the Department of Health and Public Health England and the nursing profession, will develop a bespoke older persons nurse post-graduate qualification training programme. Completion of this training programme and demonstrable expertise in working with older people will allow nurses the opportunity to become part of an Older Persons Nurse Fellowship programme that will enable nurses in this field to access a clinical academic pathway. The first cohort of students will commence on the post-graduate programme in September 2014.</p> <p>Improving hospital care for people with dementia and their carers is a key component of the Prime Minister's Challenge on Dementia. The recent <i>National Audit of Dementia Care in Hospitals</i> showed that hospitals are making progress in improving dementia care in hospitals, but that there is still work to be done. Dementia champions are in place in most hospitals, the health needs of people with dementia are better assessed and there has been a welcome reduction in antipsychotic prescribing. The</p>	<p>It is essential that those nurses caring for older people, whether in hospitals, care homes or the community, have the right compassion, skills and values to look after what can often be some of the most vulnerable people in our society. A bespoke older persons' nurse postgraduate qualification will be delivered as an annual Older Person's Nurse Fellowship. A programme for 24 participants is being commissioned from King's College London, who will make it available across the country. There will be two cohorts of 12 students. One commenced studying in November 2014 and will finish in October 2015, and the second will begin in March 2015 and finish in February 2016.</p> <p>As part of the implementation of the Prime Minister's Challenge on Dementia, on 25 July 2013 the Secretary of State for Health announced details of the 116 successful projects, 42 projects within the NHS (including hospital wards) and 74 within a local authority setting (including care homes) awarded a share of a £50million fund to create pioneering care environments designed with the needs of people with dementia in mind.</p> <p>Funding was awarded to projects that demonstrated how practical changes to the environment within which people with dementia are treated will make a tangible improvement to their condition, with work completed by end March 2014. An evaluation of the projects will published shortly, and in March 2015 the department will publish the best practice Dementia Friendly Environments Health Building Note guidance.</p>

		<p>report shows that high quality dementia care is achievable and we want to see this delivered in every hospital.</p> <p>We want people with dementia to be receiving better quality of care from informed and trained staff. Through the Commissioning for Quality and Innovation programme, NHS England has asked all hospitals to identify a senior clinical lead for dementia and to ensure that carers of people with dementia are adequately supported and that this is reported at board level. We want to see all staff being capable and competent in dementia care and, in January, we launched a new e-learning package for all health and social care staff.</p> <p>The Department of Health supported the Dementia Action Alliance in its call to action on improving the quality of care for people with dementia in hospital, which asks all NHS acute trusts to commit to become dementia-friendly and over 140 hospitals have signed up to this challenge.</p>	
201	<p>The Royal College of Nursing should consider whether it should formally divide its 'Royal College' functions and its employee representative/trade union functions and its employee representative/trade union functions between two bodies rather than behind internal 'Chinese walls'.</p>	<p>Accepted</p> <p>The Royal College of Nursing has given careful consideration to whether it should split its trade union and professional functions and has decided that it should not. The Royal College of Nursing believes it is stronger as one organisation.</p> <p>In its dual role, it believes that the elements are complementary to one another and make it a stronger organisation. It believes that trade union work is not simply consigned to fighting for better pay awards. Instead, it focuses on building a positive working environment for staff – and in healthcare that can have a direct impact on the quality of care delivered to patients.</p> <p>The Government believes the separation of the Royal College of Nursing's professional and trade union roles, which are both important, would enhance the authority of its work, so that those outside the profession would know when they were speaking in the interests solely of patients and when they were speaking solely in the interests of their members.</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>
202	<p>Recognition of the importance of nursing representation at provider level should be given by ensuring that adequate time is allowed for staff to undertake this role, and employers and unions must regularly review the adequacy of the arrangements in this regard.</p>	<p>Accepted.</p> <p>Implementation is a matter for local employers and unions. The Royal College of Nursing, UNISON and NHS Employers have endorsed this recommendation and will work with providers and commissioners to try to ensure that this is built into workforce and financial planning.</p> <p>We will explore further models to strengthen recognition of nursing representation with the Social Partnership Forum, which is a forum for employer and staff representatives.</p>	<p>The issues raised in Recommendation 202 – and the Government response – have been discussed in the Social Partnership Forum Francis Working Group. The working group included representatives from trade unions, including the Royal College of Nursing, UNISON and NHS Employers. The group felt that professional representation, not just nursing, was important at all levels of partnership working. The working group recognised the value of partnership working in the drive to improve quality and patient safety and it asked the Regional Social Partnership Forums to identify examples of effective partnership working which will be promoted on the Social Partnership Forum website.</p> <p>Although the group has now completed its work; it agreed that implementation and the development of further models would be best served locally by employers and unions.</p> <p>Case studies of effective partnership working can be found online.</p>
203	<p>A forum for all directors of nursing from both NHS and independent sector organisations should be formed to provide a means of coordinating the leadership of the nursing profession.</p>	<p>Accepted.</p> <p>The Chief Nursing Officer has established the Federation of Nurse Leaders, a national forum that has been established to raise the awareness and profile of the nursing voice at a national level. Its membership is drawn from various bodies, including the Care Quality Commission, the NHS Trust Development Authority, Health Education England, Department of</p>	<p>The Federation remains active. Recently the Nursing and Midwifery Council consulted nationally on a revised, draft Code for registrants and the Federation Group responded to this consultation with an agreed view. The Chief Nursing Officer has, with its membership, kept the Federation Group under review during 2013/14 and will continue to do so to ensure that it captures and considers key professional issues and provides the necessary challenge and support to nurses and midwives nationally.</p>

		<p>Health and Public Health England. It provides advice, challenge and scrutiny of nursing issues and provides the oversight of the delivery of <i>Compassion in Practice</i>, the vision and strategy and for nursing in England. It is chaired by the Chief Nursing Officer for England and the vice-chair is the Department of Health Director of Nursing.</p> <p>The Nursing and Care Quality forum, established by the Prime Minister in January 2012, continues to play a role in supporting the Chief Nursing Officer and advising Government on nursing and care quality issues. It has been active in highlighting the issues which need to be addressed in improving care on the national level. It has promoted the use of technology to reduce bureaucracy, emphasised the need for better leadership and recruiting health and care staff based on their values. In future it will work more closely with the Chief Nursing Officer but will also retain its independent voice.</p> <p>In addition, the Chief Nursing Officer has a monthly bulletin, an annual conference for Directors of Nursing and a new website launched to coincide with the 65th anniversary of the NHS. The website 6Cs live! provides a communications hub to enable all nurses including directors to come together, share good practice, concerns and leadership. The Chief Nursing Officer will review in 2014 whether more frequent meetings with Directors of Nursing from all organisations should take place.</p>	<p>In addition, the Chief Nursing Officer provides national professional leadership via:</p> <ul style="list-style-type: none"> • An annual programme of personal visits to health and care organisations • Production of a monthly Chief Nursing Officer bulletin • An annual summit for Directors of Nursing • A website (6CsLive!) established to serve as a hub for good practice and innovations • Blogs and her Twitter account
204	All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors.	<p>Accepted in part.</p> <p>All provider organisations have at least one executive director who is a registered nurse. NHS England has the Chief Nursing Officer on its executive board, and director level (although not executive level) representation at area and regional team levels.</p> <p>The National Health Service (Clinical Commissioning Groups) Regulations 2012 require clinical commissioning groups to have a nurse on their governing body, though not necessarily at executive level. This enables local flexibility. NHS England will consider the added value of, and mechanisms for, amending or strengthening the guidance for clinical commissioning groups on nurse leadership.</p>	NHS England is working with members of the Commissioning Nurse Leaders Network and the Royal College of Nursing to review the role of Clinical Commissioning Group nurses, including their leadership role.
205	Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.	<p>Accepted in principle.</p> <p><i>Compassion in Practice</i>, the vision and strategy for nursing in England, asks Boards to sign off and publish staffing levels. NHS England has asked that decisions on quality improvement plans are signed off by medical and nursing directors, and will consider going further to ask for their sign off on staffing changes for clinical staff as well as service provision.</p> <p>The NHS Standard Contract will be strengthened to require providers to set staffing levels on the basis of evidence, monitor actual versus intended staffing levels and share this information with commissioners and the public.</p> <p>The Chief Nursing Officer is providing leadership through <i>Compassion in Practice</i>. Key action areas include:</p> <ul style="list-style-type: none"> • Boards to sign off and publish evidence based staffing levels at least every 6 months, linked to quality of care and patient experience; and • deploying staff effectively and efficiently; identify the impact this has on quality of care and the experience of people in our care. 	In December 2013 NHS England published the NHS Standard Contract for 2014–15 , which strengthened the requirements for providers to set staffing levels on the basis of evidence, monitoring actual versus intended staffing levels and sharing information with commissioners and the public. Providers have operated under the new provisions from 1 st April 2014. The requirements are detailed within General Condition 5.2 of the Contract .
206	The effectiveness of the newly positioned	Accepted.	No further update is required. Please see response to the recommendation in

	office of Chief Nursing Officer should be kept under review to ensure the maintenance of a recognised leading representative of the nursing profession as a whole, able and empowered to give independent professional advice to the Government on nursing issues of equivalent authority to that provided by the Chief Medical Officer.	The Chief Nursing Officer for England provides professional leadership for all nurses, midwives and care staff across the healthcare system. The Chief Nursing Officer is also the principal advisor to the Government on all nursing and midwifery issues with the exception of public health nursing issues. The effectiveness of the Chief Nursing Officer role will be reviewed on an on-going basis, as will the effectiveness of the Federation of Nurse Leaders, established and chaired by the Chief Nursing Officer.	Hard Truths
207	There should be a uniform description of healthcare support workers, with the relationship with currently registered nurses made clear by the title.	Accepted in principle. This is a complex issue as healthcare support workers carry out a number of different tasks in varied roles, so a uniform description can be difficult. The <i>Cavendish Review</i> recommends that once healthcare assistants and healthcare support workers complete a ' <i>Certificate of Fundamental Care</i> ', they should be allowed to use the title 'Nursing Assistant', where appropriate. The Chief Nursing Officer has agreed to lead the work around this recommendation which should be understood as part of the wider desire to develop career development to simplified job roles and core competences framework linked to the career development framework.	Taking account of the range of allied health professionals with whom Healthcare Assistants work, the Chief Nursing Officer is planning to release guidance in 2015 on appropriate titles for people who hold the Care Certificate. This guidance will follow the Shape of Caring review, which is being chaired by Lord Willis of Knaresborough and is due to report in in early 2015. There are no plans for any similar guidance for staff working in social care
208	Commissioning arrangements should require provider organisations to ensure by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse.	We agree that patients should be clear on the role of people caring for them, for example through identity labels, clear job titles and uniforms. Many organisations already do this. However, the <i>Cavendish Review</i> does not make a firm recommendation that healthcare assistants and nurses should wear distinct uniforms, because so many Trusts already develop their own. The review does, however, support the need to provide more clarity to patients and relatives about who is looking after them. The Chief Nursing Officer will take forward work on this.	In November 2013, the National Quality Board published <u>guidance</u> to support providers and commissioners to make the right decisions about the capacity and capability of nursing, midwifery and care staffing. One of the expectations set out in the guidance is that NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift. The information displayed should be helpful and accessible to patients, and could include: the numbers of staff present on the ward, department, service or setting; who is in charge; and what the different roles and responsibilities of staff on the ward are. It could also provide relevant local information, such as the significance of different uniforms worn by staff, and titles used. Through the NHS Standard Contract for 2014/15, all commissioners require providers to have regard to this guidance.
209	A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability and/or infirmity) in a hospital or care home setting. The system should apply to healthcare support workers, whether they are working for the NHS or independent healthcare providers, in the community, for agencies or as independent agents. (Exemptions should be made for persons caring for members of their own family or those with whom they have a genuine social relationship.)	Not accepted, however we intend to achieve the intention behind this by ensuring that organisations have the right staff with the right skills to deliver care in a safe way. The Government understands that the idea of compulsory, statutory regulation can seem an attractive means of ensuring patient safety however, the Inquiry demonstrates that regulation by itself does not prevent poor care. Regulation can be costly and introduce inflexibility into the system. It should only be considered when it is shown that it is the most effective, appropriate, and proportionate means of protecting the public. We are keeping the situation under review but, currently, there is no solid evidence that demonstrates that healthcare and care support workers should be subject to compulsory statutory regulation, given the safeguards that are already in the system, such as: <ul style="list-style-type: none"> • Care Quality Commission registration, which is being enhanced with the new role of the Chief Inspectors; • the Disclosure and Barring Service which provides a further layer of assurance by helping employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups that are already in the system; and 	The Care Certificate sets out the fundamental skills, values and behaviours that healthcare assistants and social care support workers will need to demonstrate in order to provide safe, effective and compassionate care. This will provide a consistent and effective means for health and care providers to satisfy Care Quality Commission requirements that their care support workforce have the right qualifications, skills and experience. It will replace both the National Minimum Training Standards and the Common Induction Standards. Following the successful completion of pilots, the Care Certificate remains on track to be introduced for new healthcare assistants and social care support workers from 1 April 2015. From 2016 all NHS-funded student nurses in England will attain the Care Certificate within their first year of study, if they have not already achieved it. A wide range of employers and staff were engaged with the testing of the Care Certificate, the majority concluding that no radical revisions were necessary. Analysis of feedback received indicated that the draft proposals for the Care Certificate were suitable in terms of content and process The Care Quality Commission registration requirements state that all providers of regulated activities must ensure that they have the right staff with the right skills, qualifications, and experience to undertake tasks to be performed. Where providers fail to comply, the Care Quality Commission has a range of enforcement powers. The Disclosure and Barring Service provides a further layer of assurance by helping employers make safer recruitment decisions and prevent unsuitable

		<ul style="list-style-type: none"> the requirement on nurses to ensure that when they give a task to a support worker they effectively delegate, supervise and ensure the individual has the right training to do the job. <p>We recognise that there is a need to drive up standards and in 2011 the Department of Health commissioned Skills for Care and Skills for Health to develop a code of conduct and minimum training standards for healthcare assistants and support workers in England, which was published in March 2013. We welcome the recommendations of the <i>Cavendish Review</i> relevant to the importance of education, training and standards, and these are being developed further. The importance of this is recognised by the Government asking Health Education England to work with Skills for Care, Skills for Health and other stakeholders to consider how the 'Certificate of Fundamental Care' (now the Care Certificate) can be developed.</p> <p>Where employers find that a healthcare assistant or social care support worker no longer meets the standards required by the Care Certificate, Health Education England and the Sector Skills Councils will set out in guidance the requirements for ensuring that appropriate re-training is given, or other disciplinary action is taken. The guidance will be that the worker in question should not work unsupervised until the problem has been resolved and the employer is confident that their care certificate remains valid.</p>	<p>people from working with vulnerable groups.</p>
210	<p>There should be a national code of conduct for healthcare support workers.</p>	<p>Accepted.</p> <p>Skills for Health and Skills for Care published a national <u>code of conduct for healthcare support workers and adult social care workers</u> in March 2013. The <i>Cavendish Review</i> recommends that Skills for Health and Skills for Care should refine its proposed code. Skills for Health and Skills for Care will review the code to ensure the language is simple and that there is synergy with the <i>Social Care Commitment</i>, launched in September 2013, which the Department of Health has developed in conjunction with Skills for Care and other partners. The <i>Social Care Commitment</i> is the sector's promise to provide people who need care and support with safe, high quality services. It brings together other initiatives into a simple framework in simple language, giving clarity to employers and employees about what is expected of them.</p>	<p>By August 2014, 1,088 adult social care employers have signed up to the Social Care Commitment. An <u>independent evaluation report</u> has concluded that in the vast majority of cases, the Social Care Commitment has resulted in an improvement in the quality of care provided. The Social Care Commitment is also in the process of being mapped with Compassion in Practice, '6 Cs'.</p> <p>Skills for Health and its partners have recently consulted on whether the code of conduct is relevant not only to Healthcare Assistants working with nurses and midwives, but also to those who work with Allied Health Professionals. The results and amended code are expected to be published shortly. Much as the Social Care Commitment pledges employers to ensure their employees are properly supported and so can meet the Code of Conduct, Skills for Health and Skills for Care have also examined how the NHS Constitution fulfils that purpose for employers of Healthcare Assistants working in organisations providing NHS services.</p>
211	<p>There should be a common set of national standards for the education and training of healthcare support workers.</p>	<p>Accepted.</p> <p>The <u>National Minimum Training Standards</u> for healthcare support workers were published in March 2013. The <i>Cavendish Review</i> has also made a number of recommendations to improve the national standards on education and training, including a '<i>Certificate of Fundamental Care</i>.'</p> <p>An amendment to the Care Bill was tabled updating the provisions in the Health and Social Care Act 2008 that would enable regulations to specify a body that would set training standards in respect of healthcare assistants and social care support workers. This issue was debated at Report Stage by the House of Lords on 21 October. In that debate, in advance of the formal Response to the Cavendish Review, Government asked Health Education England to lead work with the Skills Councils, other delivery partners and health and care providers to develop a 'Care Certificate.'</p>	<p>The Care Certificate sets out the fundamental skills, values and behaviours that healthcare assistants and social care support workers will need to demonstrate in order to provide safe, effective and compassionate care. This will provide a consistent and effective means for health and care providers to satisfy Care Quality Commission requirements that their care support workforce have the right qualifications, skills and experience. It will replace both the National Minimum Training Standards and the Common Induction Standards. Following the successful completion of pilots, the Care Certificate remains on track to be introduced for new healthcare assistants and social care support workers from 1 April 2015. From 2016 all NHS-funded student nurses in England will attain the Care Certificate within their first year of study, if they have not already achieved it. A wide range of employers and staff were engaged with the testing of the Care Certificate, the majority concluding that no radical revisions were necessary. Analysis of feedback received indicated that the draft proposals for the Care Certificate were suitable in terms of content and process.</p> <p>Health Education England has developed a draft set of standards in conjunction with Skills for Health, Skills for Care and other delivery partners. They were</p>

			piloted across a number of health and social care providers during summer 2014. The Care Certificate is on track to be introduced for new healthcare assistants and social care support workers from 1 April 2015.
212	The code of conduct, education and training standards and requirements for registration for healthcare support workers should be prepared and maintained by the Nursing and Midwifery Council after due consultation with all relevant stakeholders, including the Department of Health, other regulators, professional representative organisations and the public.	<p>Not accepted, however we intend to achieve the intention behind this by ensuring that organisations have the right staff with the right skills to deliver care in a safe way.</p> <p>This recommendation is a step toward regulation (see recommendation 209) and for the same reasons, we are rejecting this recommendation. The Nursing and Midwifery Council also have no remit for codes of conduct for social care or healthcare support workers. The <u>Cavendish Review</u> recognises the importance of the development of education and training standards which are being developed further.</p>	No further update is required. Please see response to the recommendation in Hard Truths
213	Until such time as the Nursing and Midwifery Council is charged with the recommended regulatory responsibilities, the Department of Health should institute a nationwide system to protect patients and care receivers from harm. This system should be supported by fair due process in relation to employees in this grade who have been dismissed by employers on the grounds of a serious breach of the code of conduct or otherwise being unfit for such a post.	<p>Not accepted, however we intend to achieve the intention behind this by ensuring that organisations have the right staff with the right skills to deliver care in a safe way.</p> <p>We do not believe that regulation of healthcare assistants and support workers will improve the quality of care. The Nursing and Midwifery Council are an organisation going through a significant change programme focused around delivering their core functions relevant to the regulation of nurses and midwives, and should not be charged with these recommended regulatory responsibilities. In line with the recommendation from the <u>Cavendish Review</u> the Government has commissioned the Professional Standards Authority for Health and Social Care for advice on how employers can be more effective in managing the dismissal of unsatisfactory staff.</p> <p>The Disclosure and Barring Service provides a further layer of assurance by helping employers make safer recruitment decisions and prevent unsuitable people working with vulnerable groups.</p>	<p>The Care Quality Commission's registration requirements state that all providers of regulated activities must ensure that they have the right staff with the right qualifications, competence, skills and experience to undertake tasks to be performed. Where providers fail to comply, the Care Quality Commission has a range of enforcement powers.</p> <p>The Nursing and Midwifery Council's Code of Conduct requires nurses and midwives to delegate effectively by ensuring that anyone they delegate to is able to carry out their instructions, that the outcome of the delegated task meets required standards and that the individual delegated to is supervised and supported.</p> <p>All healthcare assistants and social care support workers should receive consistent high quality training in the fundamental skills of caring, understanding the skills and behaviours needed to deliver good care. That is why the Department of Health is introducing the Care Certificate, which will be a means of ensuring healthcare assistants and social care support workers receive the training and support they need to do their jobs.</p> <p>Supporting staff can also mean tackling underperformance in a sensitive, fair and robust manner. We should not shy away from this. In response to the Professional Standards Authority's advice to the Secretary of State, NHS Employers and the National Skills Academy for Social Care (Skills for Care) have been commissioned to develop a resource drawing together content on effective performance management and appraisal of staff providing care. This should support health and social care managers in their responsibilities to manage performance, leading to safer, higher quality care. We expect the resource to be launched in April 2015.</p>
214	A leadership staff college or training system, whether centralised or regional, should be created to: provide common professional training in management and leadership to potential senior staff; promote healthcare 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.	<p>Accepted.</p> <p>The NHS Leadership Academy, supported by NHS England, fills this role. It has developed a leadership model for the NHS and a suite of development programmes, tools and interventions to support a change in culture in NHS leadership through a national network of local delivery partners. It researches and champions the professionalisation of leadership.</p> <p>The Academy provides a suite of career-long, academically accredited programmes which map against a leadership career, irrespective of professional background. This establishes the need for prior training and development before applying for significant and vital senior roles, and creates an expectation of sufficient experience, knowledge and a minimum level of academic achievement for leadership roles. The Academy works with partners and in-house experts on developing a model for leadership, based on research evidence and best practice.</p>	<p>The NHS Leadership Academy continues to bring together national activity supporting leadership development in health and NHS funded services. To achieve this, the Academy oversees the development of core leadership programmes and a leadership model to ensure a consistent approach to leadership development of staff at all levels in the NHS.</p> <p>The Executive Fast Track programme, launched in June 2014, aims to increase the number of executive leaders in the NHS. With clinical and non-NHS backgrounds, the 49 participants are undertaking this 10-month long development programme, which includes four weeks of executive development at Harvard, Boston, USA, as well as an industrial placement and six-month long change programme under an NHS chief executive mentor.</p>

215	A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.	<p>Accepted.</p> <p>The standards produced by the Professional Standards Authority (<i>Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England</i>) provide the basis for standards for senior board-level leaders and managers. The combination of behavioural standards along with technical competence and business processes sends an important signal about the need for leaders who have the right values and behaviour as well as the ability to get the business done. The standards will form part of a wider system of ensuring that senior people are fit and proper persons that will be developed in detail in the coming months. In addition to the responsibility of individual leaders for compliance with technical and behavioural standards, the corporate structures of NHS organisations also need to both reinforce these standards and provide effective oversight of individual and corporate performance to determine whether they are being met, and what needs to be done to improve performance. The NHS Leadership Academy has published <i>The Healthy NHS Board 2013</i>, which includes guidance on supporting board effectiveness and emphasises the importance of values and behaviours.</p> <p>We agree that the public have the right to expect that people in leading positions in NHS organisations are fit and proper persons; and that where it is demonstrated that a person is not fit and proper, they should not be able to occupy such a position. Monitor and the Care Quality Commission are committed to ensuring that, taken together, their processes for registration and licensing reflect these principles. The Care Quality Commission's inspection regime will include a focus on whether or not an organisation is 'well-led'.</p> <p>In order to support this, the Government issued in July 2013 a consultation on <i>Strengthening corporate accountability in health and social care</i>. This proposes a new requirement that all Board Directors (or equivalents) of providers registered with the Care Quality Commission must meet a new fitness test. We are proposing that this test includes checks about whether the person is of good character including past employment history, and if the individual has the qualifications, skills and experience necessary for the work or office as well as the more traditional consideration of criminal and financial matters.</p>	The Care Quality Commission is taking forward the development of a 'fit and proper persons' test for board-level leaders in the organisations registered with it, whether in the public, private or voluntary sectors. Fit and Proper Persons Test Regulations have been passed by Parliament and are in place in November 2014 for NHS organisations and from April 2015 for other organisations.
216	The leadership framework should be improved by increasing the emphasis given to patient safety in the thinking of all in the health service. This could be done by, for example, creating a separate domain for managing safety, or by defining the service to be delivered as a safe and effective service.	<p>Accepted.</p> <p>The NHS Leadership Academy is developing, with extensive stakeholder involvement, a new healthcare leadership model for the NHS. This will give due emphasis to leading for patient safety.</p>	The NHS Leadership Academy's new <i>healthcare leadership model for the NHS</i> was published in November 2013. The Model is comprised of nine 'leadership dimensions' which set out the qualities that good leaders at all levels in the NHS should express. The importance of each dimension for an individual will vary based on the type of job they have, the needs of the people they work with, and the context of their role within their organisation
217	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.	<p>Accepted in part.</p> <p>The NHS Leadership Academy has developed, with extensive stakeholder involvement, a new healthcare leadership model for the NHS. In addition to technical competence, board-level leaders must also be 'fit and proper persons' in line with the registration requirements of the Care Quality Commission and Monitor.</p> <p>The standards produced by the Professional Standards Authority (<i>Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England</i>) provide the basis for standards for senior Board-level leaders and managers. The combination of behavioural standards along with technical competence and business processes sends an important signal about the need for leaders who have the right values and behaviour as well as the ability to get the business done.</p>	<p>The NHS Leadership Academy's new <i>healthcare leadership model for the NHS</i> was published in November 2013. The Model is comprised of nine 'leadership dimensions' which set out the qualities that good leaders at all levels in the NHS should express. The importance of each dimension for an individual will vary based on the type of job they have, the needs of the people they work with, and the context of their role within their organisation.</p> <p>The National Skills Academy for Social Care's <i>Leadership Qualities Framework</i> describes what good leadership looks like in different settings and situations. It mirrors the NHS Leadership Framework so that it can be applied in integrated services. The Framework describes the behaviours and competencies a good leader should display. The Academy has also developed a series of supporting assessment tools and initiatives that enable leaders to determine what areas they need to improve on in order to become excellent</p>

		<p>The public have the right to expect that people in leading positions in NHS organisations are fit and proper persons; and that where it is demonstrated that a person is not fit and proper, they should not be able to occupy such a position. Monitor and the Care Quality Commission are committed to ensuring that, taken together, their processes for registration and licensing reflect these principles. The Care Quality Commission's inspection regime will include a focus on whether or not an organisation is 'well-led'.</p> <p>Monitor's licence conditions already require providers to ensure that no person who is an unfit person may become or continue as a Director and that they ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person.</p> <p>In order to strengthen this, the Government issued in July 2013 a consultation on <i>Strengthening corporate accountability in health and social care</i>. This proposes a new requirement that all Board Directors (or equivalents) of providers registered with the Care Quality Commission must meet a new fitness test. We are proposing that this test includes checks about whether the person is of good character including past employment history, and if the individual has the qualifications, skills and experience necessary for the work or office as well as the more traditional consideration of criminal and financial matters.</p>	<p>leaders.</p> <p>The Care Quality Commission is taking forward the development of a 'fit and proper persons' test for board-level leaders in the organisations registered with it, whether in the public, private or voluntary sectors. Fit and Proper Persons Test Regulations have been passed by Parliament and are in place in November 2014 for NHS organisations and from April 2015 for other organisations.</p>
218	<p>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.</p>	<p>Accepted.</p> <p>The Care Quality Commission will work with other organisations and interested parties to determine how the fit and proper person test will be applied in practice so that it draws on the standards set out in <i>Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England</i>. We will support NHS organisations to make better use of recruitment and referencing processes to ensure that appointment processes are clear about whether or not an applicant is a fit and proper person of good standing.</p> <p>The public have the right to expect that people in leading positions in NHS organisations are fit and proper persons; and that where it is demonstrated that a person is not fit and proper, they should not be able to occupy such a position. Monitor and the Care Quality Commission are committed to ensuring that, taken together, their processes for registration and licensing reflect these principles. The Care Quality Commission's inspection regime will include a focus on whether or not an organisation is 'well-led'.</p> <p>Monitor's licence conditions already require providers to ensure that no person who is an unfit person may become or continue as a Director and that they ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person.</p> <p>In order to strengthen this, the Government issued in July 2013 a consultation on <i>Strengthening corporate accountability in health and social care</i>. This proposes a new requirement that all Board Directors (or equivalents) of providers registered with the Care Quality Commission must meet a new fitness test. We are proposing that this test includes checks about whether the person is of good character including past employment history, and if the individual has the qualifications, skills and experience necessary for the work or office as well as the more traditional consideration of criminal and financial matters.</p> <p>The Government proposes that the fit and proper persons test will now be used as a mechanism for introducing a scheme for barring Directors who are unfit from individual posts by Care Quality Commission at the point of registration. Where a Director is considered by Care Quality Commission to be unfit it could either refuse</p>	<p>The Department of Health held a consultation on a new registration requirement that all directors of providers registered with the Care Quality Commission must meet the fit and proper person test. The Care Quality Commission will be able to insist on the removal of directors that fail this test.</p> <p>Fit and Proper Persons Test Regulations have been passed by Parliament and are in place in November 2014 for NHS organisations and from April 2015 for other organisations. The Care Quality Commission held a <u>consultation</u> between July and October 2014 setting out proposals on how organisations can meet the fit and proper person test.</p>

		<p>registration, in the case of a new provider, or require the removal of the Director on inspection, or following notification of a new appointment. The Government believes that this will be a robust method of ensuring that Directors whose conduct or competence makes them unsuitable for these roles are prevented from securing them. The scheme will be kept under review to ensure that it is effective, and we will legislate in the future if the barring mechanism is not having its desired impact. Further details will be set out in the response to the consultation on corporate accountability which will be published shortly. We plan to publish the draft regulations for consultation at the same time.</p>	
219	<p>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.</p>	<p>Accepted in part.</p> <p>The Government agrees that a focus on standards and their enforcement through normal employment processes and a fit and proper person test is the right place to start. Further action may be justified following a review of how this approach works in practice; but the Government agrees that the proportionate approach is to test how well the combination of a standards-based approach and the use of a 'fit and proper persons' test by the regulators would work.</p>	<p>Fit and Proper Persons Test Regulations have been passed by Parliament and are in place in November 2014 for NHS organisations and from April 2015 for other organisations. The Care Quality Commission held a <u>consultation</u> between July and October 2014 setting out proposals on how organisations can meet the fit and proper person test. It will be the responsibility of the provider and, in the case of NHS bodies, the chair, to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria. The Care Quality Commission will work with providers, other regulators and government departments to define the processes that its inspectors will use to make these assessments and judgments. The Department of Health will keep in view how the implementation of this test is progressing as part of ongoing monitoring of the reforms.</p>
220	<p>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.</p>	<p>Accepted in part.</p> <p>We think it is essential that those who fill leadership posts should be able to demonstrate that they share in the common values of the NHS and meet expected standards in respect of both leadership skills and behaviours. We do not, however, accept the need for a formal accreditation scheme.</p> <p>A new suite of national leadership development programmes launched by the NHS Leadership Academy and supported by a revised healthcare leadership model will represent a consistent approach to developing leaders with the right skills and behaviours at all levels.</p>	<p>The NHS Leadership Academy now delivers a single, national approach to leadership development through its wide ranging suite of programmes based around the nine 'leadership dimensions' of the NHS leadership framework, which good leaders at all levels in the NHS should express. These underpin the Academy's five core leadership programmes designed to develop outstanding leaders across every tier of the healthcare system, as well as the nurse and midwife leadership programme taking forward the Prime Minister / Deputy Prime Minister commitment for 10,000 nurses and midwives to complete leadership training by March 2015.</p> <p>The Academy's core programmes are accredited and, with broader take up of the NHS leadership model in the NHS, a consistent approach to identifying and developing current and future NHS leaders with the right skills and behaviours at all levels is now being applied.</p> <p>The National Skills Academy for Social Care provides a range of training opportunities for aspiring and new leaders in adult social care. Although these opportunities are voluntary, there has been significant take up from the sector. In addition, the National Skills Academy for Social Care is running a 'Leadership for Change' training programme in conjunction with the NHS Leadership Academy, Public Health England, the Local Government Association Leadership Centre and the Virtual Staff College.</p>
221	<p>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.</p>	<p>Accepted.</p> <p>The Care Quality Commission will be responsible for ensuring that all registered providers have appropriate and effective governance arrangements in place as part of its overall assessment of the health of the organisation. This will apply regardless of whether or not an organisation is a Foundation Trust.</p> <p>One of the key questions that the Chief Inspector of Hospitals, will ask is whether or not an organisation is well-led. In addition, the NHS Trust Development Authority will be responsible for ensuring that NHS Trusts that do not have Foundation Trust status have effective governance arrangements in place. The approach used by the NHS Trust Development Authority is consistent with that used by Monitor, and both of these organisations along with the Care Quality Commission will continue to work closely to ensure that there is effective regulatory scrutiny of governance and compliance with appropriate standards. There will also be checks on quality</p>	<p>The Care Act 2014 introduced a new set of fundamental standards, which will apply to all providers from April 2015. Under the Care Quality Commission's new inspection regime lead by the chief inspectors of hospitals, adult social care, and general practice, every service and provider is ask five questions:</p> <ul style="list-style-type: none"> • Are they safe? • Are they effective? • Are they caring? • Are they well led? • Are they responsive to people's needs? <p>The Care Quality Commission consulted on its proposals on how organisations can meet the fundamental standards which include the fit and proper person test as part of the 'well led' domain. The <u>consultation</u> concluded in October 2014.</p> <p>Fit and Proper Persons Test Regulations have been passed by Parliament and are in place in November 2014 for NHS organisations and from April 2015 for</p>

		governance by the NHS Trust Development Authority before referral to Monitor.	other organisations. The Care Quality Commission held a <u>consultation</u> between July and October 2014 setting out proposals on how organisations can meet the fit and proper person test.
222	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.	<p>Accepted.</p> <p>The General Medical Council has made it clear that it recognises the need to contribute to the identification and in some cases the investigation of generic concerns, building on its progress in recent years to become a more proactive and collaborative regulator. This includes signposting complainants to the appropriate regulator if their concerns are not for the General Medical Council; making referrals to systems or other professional regulators; investigating concerns arising from the media (including those which do not specifically name a doctor) and sharing information with and participating in regional quality surveillance groups and risk summits. In light of this recommendation, the General Medical Council will undertake to clarify in what circumstances it has an interest in generic reports or complaints and continue to build its relationship with the Care Quality Commission to ensure appropriate leadership in relation to generic concerns. We will continue to work with the General Medical Council and other organisations to ensure that communication and effective sharing of information between regulators of all kinds works well and in the interests of patients.</p>	<p>Direct interventions by the General Medical Council will be confined to matters within its regulatory remit in the quality of education and of individual practitioners.</p> <p>It contributes to the identification and investigation of systemic or generic concerns outside its direct remit by signposting complainants to the appropriate regulator, making referrals to systems or other professional regulators, investigating concerns that are raised in the media and sharing information with and participating in Regional Quality Surveillance Groups and Risk Summits. The General Medical Council has established an internal Patient Safety Intelligence Forum to coordinate information that may demonstrate concerns about patient safety or medical practice and ensure the appropriate operational and policy response across its functions relevant to operational or thematic risk. This Forum will continue to develop throughout 2014 and 2015 in parallel with the development of the General Medical Council's enhanced data strategy.</p>
223	If the General Medical Council is to be effective in looking into generic complaints and information it will probably need either greater resources, or better cooperation with the Care Quality Commission and other organisations such as the Royal Colleges to ensure that it is provided with the appropriate information.	<p>Accepted in principle.</p> <p>The General Medical Council has made it clear that it is determined to improve the way it shares information and works with other regulators and organisations such as the medical Royal Colleges. The General Medical Council has agreed an information sharing protocol with the Care Quality Commission, which builds on the existing memorandum of understanding, to ensure that both organisations work closely and effectively together to share information and ensure appropriate and effective cross-referral of concerns.</p>	<p>The General Medical Council has developed an Operational Protocol with the Care Quality Commission, and is developing a joint approach to the evaluation of the operating protocol, with a full evaluation scheduled for September 2015. Additionally, progress is continuing on the development of refreshed or new Memorandas of Understanding or information sharing agreements with the NHS Trust Development Authority and Monitor. Operational protocols will be developed to practically support these Memoranda of Understanding and information sharing agreements.</p> <p>The General Medical Council and the Care Quality Commission agreed a refreshed Operational Protocol in December 2014 and an approach to evaluating it. An interim evaluation report will be published in March 2015.</p> <p>In addition, the General Medical Council has developed a new "information sharing manual" for Fitness to Practise" colleagues. This details at an operational level how, when and who the General Medical Council will share information with. Core joint training was launched in December 2014 at both the Care Quality Commission and the General Medical Council offices and the General Medical Council have supported the roll out of advanced training in January 2015.</p> <p>A refreshed Memoranda of Understanding was agreed between the general Medical Council and the NHS Trust Development Authority in December 2014 and the General Medical Council are continuing to develop an Memoranda of Understanding with Monitor, agreement of which is expected during the first quarter of 2015. Operational Protocols will also be developed to support both of their implementation during the first quarter of 2015.</p>
224	Steps must be taken to systematise the exchange of information between the Royal Colleges and the General Medical Council, and to issue guidance for use by employers of doctors to the same effect.	<p>Accepted.</p> <p>The General Medical Council has made it clear that the exchange of information with Royal Colleges should be further systematised, and that it will take forward action to ensure that this takes place. The General Medical Council will share its proposals in the first half of 2014.</p> <p>The General Medical Council will work with the Royal Academy of Medical Royal</p>	<p>In February 2014 the General Medical Council published the results of a review of its arrangements for quality assuring medical education and training. One of the main issues highlighted in the review was the importance of effective information sharing between the General Medical Council and the Royal Colleges. The General Medical Council is currently considering how to enhance further current information sharing arrangements with Royal Colleges, with the aim of developing formal agreements with them. A working group has also been established to look at the data held by the Royal Colleges and the General</p>

		<p>Colleges to develop information sharing agreements with all of the Medical Royal Colleges. In relation to education and training the General Medical Council has made it clear that the exchange of information with Royal Colleges should be further systematised, and that it will take forward action to ensure that this takes place. The General Medical Council will share its proposals in the first half of 2014.</p> <p>The General Medical Council has developed a closer working relationship with employers through the Employer Liaison Service. It already produces guidance to help employers understand when to share information with the General Medical Council and will reiterate this guidance through meetings with Responsible Officers and Medical Directors.</p>	<p>Medical Council, and the best way to use and share this data. The General Medical Council has now begun providing a richer set of tailored, targeted data to the Royal Colleges and gathering further information from the Royal Colleges to inform the General Medical Council's programme of visits</p> <p>Further, the General Medical Council is beginning to gather further information from Royal Colleges to inform its regional visits programme and, in addition, has invited members of Royal Colleges to support the General Medical Council on selected visits (where its visitor pool does not include the appropriate expertise).</p>
225	<p>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.</p>	<p>Accepted.</p> <p>The General Medical Council has made it clear that it is determined to work with others to explore the development of appropriate forms of joint ownership of generic issues, so that unacceptable patient care is identified and dealt with effectively. This may include (but need not be confined to) peer reviews.</p>	<p>The General Medical Council contributes to the identification and investigation of system or generic concerns by means of its Operational Protocol with the Care Quality Commission and the development of information sharing agreements with other systems regulators. In addition, it shares information with, and participates in, Regional Quality Surveillance Groups and Risk Summits.</p>
226	<p>To act as an effective regulator of nurse managers and leaders, as well as more front-line nurses, the Nursing and Midwifery Council needs to be equipped to look at systemic concerns as well as individual ones. It must be enabled to work closely with the systems regulators and to share their information and analyses on the working of systems in organisations in which nurses are active. It should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures. Full access to the Care Quality Commission information in particular is vital.</p>	<p>Accepted in part.</p> <p>The Nursing and Midwifery Council have made it clear that they are determined to work closely with other regulators, including the Care Quality Commission to share information and analyses, and that it should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures. The Government notes that the Nursing and Midwifery Council have stated that they do not wish to be given the role of directly investigating systems issues given that the primary responsibility for such issues rests with the Care Quality Commission, but that they intend to address the underlying issue identified in this recommendation by working closely with the Care Quality Commission and other regulators to ensure that the most serious matters are appropriately addressed in a systematic manner.</p>	<p>The Nursing and Midwifery Council and the Care Quality Commission have refreshed their Memorandum of Understanding that sets out how and when to share information, and are developing a protocol to support staff in implementing the commitments in it. The Nursing and Midwifery Council provides the Care Quality Commission with data from its work on settings due for inspection and is working to improve the quality and accessibility of this data. It has agreed a data strategy to support those improvements.</p> <p>The Nursing and Midwifery Council is undertaking an internal quality assurance exercise on its own practice under its Memoranda of Understanding, the results of which will inform Memoranda being developed with other regulators. It will first report on the activity occurring as a result of partnership agreements and then undertake a more qualitative assessment of the impact of its own practice on safety and quality.</p> <p>In its materials about how to raise concerns, the Nursing and Midwifery Council helps to signpost the role of system regulators to registrants and members of the public.</p>
227	<p>The Nursing and Midwifery Council needs to have its own internal capacity to assess systems and launch its own proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues. It may decide to seek the cooperation of the Care Quality Commission, but as an independent regulator it must be empowered to act on its own if it considers it necessary in the public interest. This will require resources in terms of appropriately expert staff, data systems and finance. Given the power of the registrar to refer cases without a formal third party complaint, it would not appear that a change of regulation is necessary, but this should be reviewed.</p>	<p>Accepted in principle.</p> <p>The Nursing and Midwifery Council are taking a different approach to achieving this recommendation. The Nursing and Midwifery Council is committed to working closely with the Care Quality Commission and with other regulators to ensure that the most serious matters are appropriately addressed in a systematic manner.</p>	<p>See response to 226. The Nursing and Midwifery Council uses its powers to open cases if there is public interest in doing so. Where it has a statutory role in systems – through education and midwifery supervision – the Nursing and Midwifery Council takes joint action with the Care Quality Commission when that is the most effective way of protecting the public.</p>

228	<p>It is of concern that the administration of the Nursing and Midwifery Council, which has not been examined by this Inquiry, is still found by other reviews to be wanting. It is imperative in the public interest that this is remedied urgently. Without doing so, there is a danger that the regulatory gap between the Nursing and Midwifery Council and the Care Quality Commission will widen rather than narrow.</p>	<p>Accepted.</p> <p>The Nursing and Midwifery Council has made clear its commitment to implementing the recommendations and achieving the required improvements in the delivery of its regulatory functions set out in the strategic review undertaken by the Professional Standards Authority in 2012, most recently in its 2013-2016 corporate plans.</p> <p>In relation to the recommendation to appoint a strong leadership team to drive forward turn around work, Mark Addison was appointed Chair of the Nursing and Midwifery Council in September 2012, and Jackie Smith was permanently appointed to the role of Nursing and Midwifery Council Chief Executive in June 2013. In addition, the Nursing and Midwifery Council was re-constituted from 1 May 2013.</p> <p>The Government has demonstrated its determination to ensure the Nursing and Midwifery Council is an effective regulator that serves its members well. In February 2013, the Government provided a £20m grant to support the Nursing and Midwifery Council to achieve a number of improvements including clearing a backlog of historical fitness-to-practise cases, speeding up fitness to practise proceedings, ensuring free financial reserves are at agreed levels and reducing the effect of an annual fee rise for nurses and midwives. Departmental officials continue to closely scrutinise and monitor the Nursing and Midwifery Council's progress in making the required improvements within the timescales specified.</p> <p>In addition, the Government is working on an order under section 60 of the <i>Health Act 1999</i> to amend the Nursing and Midwifery Order 2001. This is in advance of any measures which may be taken forward following the Law Commission review which is considering the overhaul of the complex legislative framework that governs the Nursing and Midwifery Council and the regulators of other UK health professionals and, in England, social care professionals into a single Act, subject to Parliamentary timetables. Within this section 60 order the Government intends to make a number of amendments including change to achieve greater efficiency in fitness to practise procedures, including a reduction in the overall time that a case takes from start to finish.</p>	<p>The Nursing and Midwifery Council commissioned an independent review to assess its progress in addressing recommendations made in the Professional Standards Authority's Strategic Review of it. The report from this review was published on 15 September 2014. The review concluded that the Nursing and Midwifery Council has made a substantial number of improvements, which cumulatively place it in a much stronger position than in 2012. However, it also highlights areas where the Nursing and Midwifery Council needs to continue to make progress.</p> <p>The 2012 Strategic Review was clear that high quality leadership was critical to restoring confidence in the Nursing and Midwifery Council's reputation as an effective regulator. In September 2014, the Nursing and Midwifery Council announced that Professor Dame Janet Finch DBE had been appointed as its next Chair from January 2015.</p> <p>In summer 2014 the Nursing and Midwifery Council had cleared the backlog of historical fitness-to-practise cases in advance of its December 2014 target, and has increased the number of hearings to more than 22 per day in order to meet the adjudication target by December 2014.</p> <p>The Nursing and Midwifery (Amendment) Order 2014 came into force on the 11th December 2014. The Order made amendments to the Nursing and Midwifery Council's governing legislative framework. Associated amendments to the Nursing and Midwifery Council's rules will come into force in March 2015. The amendments in the Order give the Nursing and Midwifery Council powers to carry out its fitness to practise role and functions more effectively, enabling complaints to be dealt with more quickly and resulting in improved public protection.</p>
229	<p>It is highly desirable that the Nursing and Midwifery Council introduces a system of revalidation similar to that of the General Medical Council, as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. It is essential that the Nursing and Midwifery Council has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.</p>	<p>Accepted.</p> <p>The Nursing and Midwifery Council has committed to introducing a proportionate and effective model of revalidation, which is affordable and value for money, to enhance public protection. Subject to public consultation, the proposed model would require evidence that the nurse or midwife is fit to practise. Under the current proposals, the Nursing and Midwifery Council Code and standards would be reviewed and revised to ensure they would be compatible with revalidation, and guidance for revalidation would also be developed.</p>	<p>In February 2013, the Nursing and Midwifery Council began a UK-wide programme of engagement on revalidation and has held two national consultations. The first ran from January to March 2014 and focused on the proposed model of revalidation. The second, which ran from May to August 2014, included a draft revised Code intended to address, for example, putting patients first (including a greater emphasis on providing the fundamentals of care, hydration and nutrition); dealing with complaints; raising concerns ('whistle-blowing'); the professional duty of candour; and leadership, delegation and team working.</p> <p>The Nursing and Midwifery Council will test the resulting revalidation model in a pilot during 2015 and full implementation of the model will commence by the end of 2015. The Nursing and Midwifery Council has established an oversight board that will drive forward the planning and confirm that the UK is sufficiently ready for implementation.</p>
230	<p>The profile of the Nursing and Midwifery Council needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed, by those providing treatment or care, of the existence and role of the Nursing and Midwifery Council, together with contact details. The Nursing and Midwifery</p>	<p>Accepted.</p> <p>The Nursing and Midwifery Council is working to develop its public profile, and will be re-launching its website and developing information for patients, the public and employers. It has embarked on a programme of increased face-to-face engagement with its stakeholders and introduced a new patient and public forum made up of patient advocates, health charities and members of the public. The group meet quarterly and have considered issued</p>	<p>The Nursing and Midwifery Council is making progress with its website redevelopment project and has recently completed a phase of user testing to inform the architecture of the site. The revised website is due to be launched by mid-2015. Its Patient and Public Engagement Forum continues to meet quarterly and advises the Nursing and Midwifery Council on raising public awareness of its role and how to ensure its services are accessible to all potential users.</p>

	<p>Council itself needs to undertake more by way of public promotion of its functions.</p>	<p>such as what can be done to restore confidence in the Nursing and Midwifery Council, and patients' experience of complaining to the Nursing and Midwifery Council. The forum is helping the Nursing and Midwifery Council to co-create a leaflet for the public on the quality assurance of education and how to make the Nursing and Midwifery Council's website more user-friendly.</p> <p>As part of its engagement work, the Nursing and Midwifery Council has held a joint event with the Richmond Group of Charities and the General Medical Council involving representatives from regulators, health charities, patient advocacy groups and others to discuss what good patient and public engagement feels like. The council is also part of the health professions regulators patient and public engagement group to share experiences and look at ways to work better together.</p> <p>In September 2013, the Nursing and Midwifery Council relaunched its guidance on raising concerns, and is publicising this guidance through various means. Its engagement work covers all its functions, including fitness-to-practise, registration, education, standards and revalidation and is undertaken across all four UK countries. This work will be enhanced further by the planned introduction of regional representatives.</p>	<p>The Nursing and Midwifery Council has produced two information <u>leaflets</u> for the public on raising concerns about nurses and midwives and understanding your rights when being cared for by students. These leaflets have been distributed widely through over 1,000 patient representative groups, patient advocacy services, patient advice and liaison</p>
231	<p>It is essential that, so far as practicable, Nursing and Midwifery Council procedures do not obstruct the progress of internal disciplinary action in providers. In most cases it should be possible, through cooperation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures, to make it clear that the employer is entitled to proceed even if there are pending Nursing and Midwifery Council proceedings.</p>	<p>Accepted.</p> <p>The Nursing and Midwifery Council have made clear their view that their procedures should not obstruct internal disciplinary action, and that it would not expect the making of an interim order by the Nursing and Midwifery Council to prevent the completion of disciplinary action. The Nursing and Midwifery Council will review the guidance it provides to employers and the public to ensure that this issue is addressed clearly.</p>	<p>The Nursing and Midwifery Council maintains the position that any interim order imposed by the Nursing and Midwifery Council should not impact further disciplinary action by the employer with regards to an individual nurse or midwife. The Nursing and Midwifery Council continue to work with employers to ensure they are aware of any action being undertaken by the Nursing and Midwifery Council and that they are aware of their role in the process.</p>
232	<p>The Nursing and Midwifery Council could consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing. If this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap.</p>	<p>Accepted.</p> <p>The Nursing and Midwifery Council have started planning the introduction of new regional advisors who will perform a function similar to the General Medical Council's employer liaison advisers of providing support and guidance locally for employers and others with concerns about nurses and midwives. A pilot will be undertaken in 2014, with roll out planned for 2015.</p>	<p>The Nursing and Midwifery Council have engaged with our external stakeholders and obtained their views on what a regional liaison model might look like. These discussions were designed to develop an understanding of the key issues relating to regional engagement which would then inform the approach to developing a model for Nursing and Midwifery Council regional liaison. The stakeholders included nursing and midwifery representatives from employers and partners throughout the UK, across the NHS and independent sectors as well as wider regulators. An operating model is being developed for rollout in early 2015.</p>
233	<p>While both the General Medical Council and the Nursing and Midwifery Council have highly informative internet sites, both need to ensure that patients and other service users are made aware at the point of service provision of their existence, their role and their contact details.</p>	<p>Accepted.</p> <p>Both the General Medical Council and the Nursing and Midwifery Council have made clear their commitment to ensure that patients and the public have a clear understanding of the role of both organisations.</p> <p>The General Medical Council is piloting meetings with patients and relatives who have made a complaint about a doctor. During the pilot, they are offering to meet individual complainants at the beginning and end of the case. The aim is to make sure that the complainant fully understands the nature and purpose of the General Medical Council's procedures and that the General Medical Council fully understands the nature of the complainant's concerns. The meeting when the case has concluded gives the General Medical Council an opportunity to explain the outcome.</p>	<p>The Nursing and Midwifery Council is making progress with its website redevelopment project and has recently completed a phase of user testing to inform the architecture of the site. The revised website is due to be launched by mid-2015. Its Patient and Public Engagement Forum continues to meet quarterly and advises the Nursing and Midwifery Council on raising public awareness of its role and how to ensure its services are accessible to all potential users.</p> <p>The Nursing and Midwifery Council has produced two information <u>leaflets</u> for the public on raising concerns about nurses and midwives and understanding your rights when being cared for by students. These leaflets have been distributed widely through over 1,000 patient representative groups, patient advocacy services, patient advice and liaison</p> <p>The General Medical Council is committed to ensuring patients and the public have a clear understanding of the role of the organisation. It has commissioned a report into the confidence and awareness of the General Medical Council functions and the effect of current communication channels, including its website, which will be published by early 2015.</p>

			<p>In 2012 the General Medical Council piloted a Patient Information Service with the aim of improving communications with members of the public who raise concerns about a doctor. The General Medical Council held a total of 298 meetings with patients, both at the beginning and end of our Fitness to Practise processes. An independent evaluation of the pilot found that meetings had mostly provided patients with a better understanding of the General Medical Council's processes. They felt listened to and felt their complaint was being taken seriously. Meetings were also helpful in reducing their feelings of isolation. The evaluation report was published on our website in September 2014 and in January 2015 the pilot was rolled out to the General Medical Council's offices across the UK, in Manchester and London, as well as Cardiff, Edinburgh and Belfast.</p>
234	<p>Both the General Medical Council and Nursing and Midwifery Council must develop closer working relationships with the Care Quality Commission – in many cases there should be joint working to minimise the time taken to resolve issues and maximise the protection afforded to the public.</p>	<p>Accepted.</p> <p>The General Medical Council has been working closely with the Care Quality Commission to build on its Memorandum of Understanding. Similar close joint working has also started with the Nursing and Midwifery Council.</p> <p>The Care Quality Commission and General Medical Council have already reviewed their joint working arrangements to improve information sharing, allow evaluation and tracking of how information is used, and plan coordinated or joint inspections and visits. These arrangements were published in July 2013.</p> <p>The Care Quality Commission and the Nursing and Midwifery Council began a similar review during September 2013, to develop a similar joint working protocol by December 2013.</p> <p>The Care Quality Commission issued <i>Raising Standards, putting people first – our strategy 2013 – 16</i> in February 2013. This set out the Care Quality Commission's plans for the next three years and made clear that it would work more closely with its partners in the health and social care system to improve the quality and safety of care and co-ordinate work better, including working with other regulators and organisations that manage and oversee the health and social care system to identify and act on the public's concerns. This was reinforced in June 2013, when the Care Quality Commission issued its consultation document 'A new start – Consultation on changes to the way Care Quality Commission regulates, inspects and monitors care'. This recognised the need to coordinate with existing visits and inspections to minimise duplication and overlap, for example through joint visits and re-use of each other's findings.</p>	<p>The Nursing and Midwifery Council and the Care Quality Commission renewed their Memorandum of Understanding in December 2013; this is now supported by a clear joint working protocol for staff of both organisations. The Nursing and Midwifery Council is conducting an internal quality assurance exercise looking at activity under the new Memorandum of Understanding and the learning will inform next steps for improving partnership working.</p> <p>The General Medical Council has developed an Operational Protocol with the Care Quality Commission and both organisations will agree a joint approach to its evaluation. An interim evaluation report will be published in March 2015. Initial feedback from staff in both organisations indicates that the Protocol is working well.</p> <p>Between 09 April and 04 June 2014, the Care Quality Commission consulted on how it planned to change the way it regulates, inspects and rate care services. The changes include things like:</p> <ul style="list-style-type: none"> • what the Care Quality Commission look at on an inspection. • how the Care Quality Commission judge what 'good' care looks like. • how the Care Quality Commission rate care services to help people judge and choose care if they want to. • how the Care Quality Commission use information to help decide when and where to inspect. <p>The Care Quality Commission has also published consultation handbooks for seven types of provider (see recommendation 14). In July 2014, the Care Quality Commission published a consultation on <u>guidance</u> for providers meeting the fundamental standards and on the Care Quality Commission's enforcement powers. The consultation closed on 17 October 2014. The Care Quality Commission is considering the responses and will publish its new guidance prior to April 2015.</p>
235	<p>The Professional Standards Authority for Health and Social Care (PSA) (formerly the Council for Healthcare Regulatory Excellence), together with the regulators under its supervision, should seek to devise procedures for dealing consistently and in the public interest with cases arising out of the same event or series of events but involving professionals regulated by more than one body. While it would require new regulations, consideration should be given to the possibility of moving towards a common independent tribunal to determine fitness</p>	<p>Accepted in part.</p> <p>The Professional Standards Authority oversees the work of the professional regulators, but it has no powers to intervene directly in cases (save that where it considers the outcome of a fitness to practise hearing has been unduly lenient it may refer the case for consideration by the high court). The Law Commission is undertaking a review of the legislation applicable to the regulators with a view to producing a draft Bill containing proposals for reform.</p> <p>Within this it has consulted on proposals which would provide powers for joint working between the regulators. We supported these proposals and, subject to the outcome of the consultation, would wish to consider taking them forward at a suitable legislative opportunity. If implemented, it would be for the regulators to determine how they are used but they</p>	<p>The Law Commission published their Report and proposed draft Bill containing recommendations for reforming the regulation of healthcare professionals on 02 April 2014. This included a recommendation that any two or more regulators should be able to arrange for any of their respective functions to be exercised jointly. It also recommended that the Professional Standards Authority should be given a general function to promote co-operation between the regulators in relation to the performance of their functions.</p> <p>The Government agrees legislation should empower regulators to look for ways in which they can work together and make best use of their respective skills and resources to better support public protection. The Government also agrees the Professional Standards Authority for Health and Social Care should have a specific role in promoting best practice in this respect, identifying opportunities for co-operation between the professional regulators and, as part of their annual</p>

	to practise issues and sanctions across the healthcare professional field.	would potentially enable greater co-operation and, thereby, greater consistency between regulators in cases affecting more than one class of professional. The Law Commission's consultation also included the possibility that regulators would be able to use these powers to share tribunal services for the determination of fitness to practice cases, although the full implications of this would need to be considered further.	performance review of each regulator, monitoring progress made towards this. The Government response to the Law Commission was published on 29 January 2015 and legislation will be brought forward when Parliamentary time allows.
236	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	<p>Accepted.</p> <p>In his speech on patient safety on 21 June 2013, the Secretary of State for Health signalled his support for the practice of hospitals identifying a named consultant who is responsible for a patient's care. This happens in a number of Trusts already – University College London Hospitals NHS Foundation Trust and Kings College Hospital in London have agreed to introduce it and the Department would encourage others to do so, including mental health providers. At a seminar hosted by the Academy of Medical Royal Colleges on 25 September 2013, it was clear there was a strong professional consensus on this approach and the Academy is leading work to take it forward. The Academy will produce key principles with worked examples on how this can be implemented in a way that sustains professional support.</p> <p>The Government is also proposing the introduction of a named accountable clinician for patients receiving care outside hospitals, starting with vulnerable older people. The Government proposes that the most vulnerable elderly would benefit from having someone in primary care taking responsibility for ensuring that their care is coordinated and proactively managed. Just as patients in hospitals are under the care of a named consultant, we need to ensure that when a vulnerable older patient needs follow-up or ongoing support having left hospital, that somebody is accountable for their care. Although this clinician may not provide the care directly themselves, they would be the person with whom the buck stops and would be an identifiable point of contact for a patient or their family.</p> <p>The Government has been testing its proposals over the summer through engagement with patients, carers, health and social care staff, and will be setting out its plan for improving out-of-hospital care for vulnerable older people later in the year. This was reflected in the refreshed Mandate to NHS England for 2014–15.</p>	<p>Following the Secretary of State for Health's support for hospitals to reintroduce the practice of placing the name of the responsible nurse or doctor above a patient's bed, so making it clear the responsible clinician for that patient's care during their stay in hospital, the Academy of Medical Royal Colleges agreed to lead the work with the professional community to produce guidance. This guidance has a strong professional consensus around it – and the various contributing Royal Colleges have signed up to it and have been promoting it with their members.</p> <p>The guidance describes the purpose of the responsible clinician role and named nurse with some key considerations for implementation including:</p> <ul style="list-style-type: none"> • the overall responsibilities for the coordination and continuity of a patient's care during their hospital stay including discharge, any transfers within hospital and readmission; • the role as a point of contact for the patient, their carers and family (the guidelines includes a set of key messages to patients that hospitals might wish to use); • the role of the named nurse role recognising the need for more flexibility because of shift working arrangements; and • displaying information about accountable clinicians including the importance of patient consent. <p>To date more than two thirds of Trusts reported that they have implemented the 'Name Above the Bed' or a similar initiative. The General Medical Council is also working with the Academy of Medical Royal Colleges to strengthen the professional, non-technical skills needed by doctors in postgraduate curricula. The adoption of the Academy of Medical Royal Colleges' guidance on the role of the responsible clinician will be reflected in the regulatory and planning frameworks of the NHS. The Government will also be discussing with the professions, NHS England and employers what further action is needed to foster a stronger culture of professional responsibility for individual patients and ensuring continuity of care for people with complex and multiple needs. As part of this, the Academy of Medical Royal Colleges has now agreed to consider developing this approach to apply outside of the inpatient setting and will publish preliminary findings in the spring of 2015. The Academy of Medical Royal Colleges is developing for May 2015 a new definition of clinical accountability that will span hospital and out-of-hospital care. NHS England will ask clinical commissioning groups to publish by the end of 2015 the percentage of their patient population living with long-term conditions who are receiving care and support in line with this definition.</p>
237	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued	<p>Accepted.</p> <p>All staff should recognise that they impact on patient experience and take responsibility for their contribution to patients having a positive experience of care. Research commissioned by the Department of Health has shown that effective teamwork is crucial to the delivery of improved patient care in a culture of safety and quality.</p> <p>As part of its Mandate for 2013–15, the Government has asked Health Education England to implement improvements to GP training to include more emphasis on care of the elderly; work-based training modules in mental health, including dementia; and</p>	<p>Health Education England are taking forward current mandate commitments on General Practice Training, including more emphasis on care of the elderly and work-based training modules in mental health, including dementia as part of many other work-streams including Shape of Training and Mental Health.</p> <p>The Care Certificate is being piloted with a view to rolling out across England. This aims to improve the status and quality of caring in all settings. The Care Certificate will be a means of providing assurance that healthcare assistants and social care support workers receive the high quality and consistent training and support they need to do their jobs. This should ensure that they understand the skills required and demonstrate the behaviours needed to deliver compassionate</p>

		<p>an understanding of working in multi-disciplinary teams to deliver good integrated care.</p> <p>Camilla Cavendish's review raised the need to improve recruitment, training, development and supervision of health and social care support workers. The Government has asked Health Education England to lead the work with Skills Councils, and other delivery partners to develop a 'Certificate of Fundamental Care', relabelled as the 'Care Certificate'. This will provide assurance that healthcare assistants and social care support workers receive high quality training and consistent training and support they need to do their jobs. This should ensure that they understand the skills required and demonstrate the behaviours needed to deliver compassionate care across health and social care and help raise the status of caring.</p> <p>Further delivery is for local consideration and action – The Inquiry made clear that Trusts/ organisations do not need to wait for a Government response before taking local action. However, the Department has asked NHS Employers to collate some of the resources available to employers to support team development and effective team working, and to create a web page with links to these resources. This will be made available to employers by the end of 2013.</p> <p>Royal Wolverhampton Hospitals NHS Trust have ensured all their staff are dementia-trained, with the level of training varying from basic awareness to specialised dementia care training. Non clinical staff, such as receptionists, porters and catering staff are all trained to spot the signs of dementia and respond appropriately to people with the condition.</p> <p>112. Michael West, Richard Baker, Jeremy Dawson, Mary Dixon Woods, Richard Lilford, Graham Martin, Lorna McKee, Madeleine Murtagh, Patricia Wilkie, Quality and Safety in the NHS: Evaluating Progress, Problems and Promise, 2013,</p>	<p>care across health and social care and help raise the status of caring.</p> <p>Dementia awareness training is being rolled out across England for all healthcare staff with more in-depth training for expert leaders and all staff working with people living with dementia.</p> <p>Health Education England will contribute to the Department of Health/NHS England <i>Transforming Primary Care</i> initiative that includes a focus on ensuring General Practice training provides support to specific groups including care of older people. Health Education England has developed a draft set of standards in conjunction with Skills for Health, Skills for Care and other delivery partners. These were piloted across a number of health and care providers during summer 2014. Subject to evaluation, the Certificate will be introduced for new care assistants from March 2015.</p>
238	<p>Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds:</p> <ul style="list-style-type: none"> 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 	<p>Accepted.</p> <p>All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors.</p> <p>As part of its Mandate for 2013-2015, the Government has asked Health Education England to work with healthcare providers, regulators and educational institutions to ensure both recruitment and selection for training curricula identify and reinforce the values and behaviours identified in the NHS Constitution.</p> <p>Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients.</p> <p>The Department of Health's Health Building Note 04-01, published in December 2012, provided best practice guidance on the planning and design of in-patient facilities for adults. The Note recognises the need for breakout space and informal social space to enable patients to socialise, and interview rooms for more private discussions. Planning decisions should take account of privacy, modesty and same-sex accommodation.</p> <p>As part of the implementation of the Prime Minister's Challenge on Dementia, on 25 July 2013 the Secretary of State for Health announced details of the 116 successful projects, 42 projects within the NHS (including hospital wards) and 74 within a local authority setting (including care homes) awarded a share of a £50million fund to create pioneering care environments designed with the needs of people with dementia in mind.</p> <p>Funding was awarded to projects that demonstrated how practical changes to the environment within which people with dementia are treated will make a tangible</p>	<p>Health Education England has begun to promote the assessment of values as part of the recruitment process into NHS employment with the intentions of evaluating the impact recruiting for values has on the system. In support of this, Health Education England developed three work streams: recruitment into NHS funded training programmes; recruitment into NHS employment; and evaluating the impact of recruiting for values.</p> <p>During October 2014, Health Education England published the national <u>Values Based Recruitment framework</u>, which functions as an interactive resource including the evidence base, case studies and available resources. The resources NHS Employers have published to date are incorporated within the Values Based Recruitment framework, which is intended to run until March 2015. Following the publication of this document, further workshops, case studies and resources will be published. In addition, work will continue to support organisations with their Values Based Recruitment projects and for NHS Employers to maintain the partner network. As local Values Based Recruitment projects develop, the national programme will flex to accommodate the framework's needs. For employers, Values Based Recruitment will not be mandatory but will be recommended as best practice.</p> <p>As part of the implementation of the Prime Minister's Challenge on Dementia, on 25 July 2013 the Secretary of State for Health announced £50million fund to create pioneering care environments designed with the needs of people with dementia in mind. An evaluation of the projects will published shortly, and in March 2015 the department will publish the best practice Dementia Friendly Environments Health Building Note guidance.</p>

	<p>partnership to which all patients are entitled.</p>	<p>improvement to their condition. Evidence and findings from these projects will be gathered and developed into policy and to inform best practice guidance for the NHS and Social Care providers.</p> <p>The many strands of work to implement the Government's information strategy for health and care in England are beginning to bring improvements for patients and services, for example being able to book appointments and order repeat prescriptions online and communicate electronically with health and care professionals.</p> <p>As it becomes more normal to communicate with our health and care professionals in ways that suit our own circumstances and interact with health and care services electronically, the Department would expect this change to extend to increasing use of technology for appropriate communications with carers, families and relatives. The Information Strategy published in 2012, <i>The Power Of Information</i>, set out an ambition that 'We need to be able to communicate with our health and care professionals in ways that suit our own circumstances.' It referenced the example of online care plans in Graham Care Group homes, as follows:</p> <p>'Following initial trials at Rodwell Farm Nursing Homes, all residents in the Graham Care Group homes, their relatives and friends can now access securely current care plans and daily reports via email, internet, iPhone etc. Designated contacts can receive text alerts or emails notifying them that updates have been uploaded. The newest and most innovative part of the system allows families and friends to use a text-based system to supply information, photographs etc, which designated care staff will share with residents. The system is being evaluated by the University of Surrey.'</p> <p>The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered.</p> <p>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.</p> <p>The Government proposes that the most vulnerable elderly would benefit from having someone in primary care taking responsibility for ensuring that their care is coordinated and proactively managed. Just as patients in hospitals are under the care of a named consultant, we need to ensure that when a vulnerable older patient needs follow-up or ongoing support having left hospital, that somebody is accountable for their care. Although this clinician may not provide the care directly themselves, they would be the person with whom the buck stops and would be an identifiable point of contact for a patient or their family.</p> <p>The Government has been testing its proposals over the summer through engagement with patients, carers, health and social care staff, and will be setting out its plan for improving out-of-hospital care for vulnerable older people in December 2014. This was reflected in the refreshed the Government's Mandate for NHS England for 2014–15.</p> <p>In its initial response to The Inquiry, <i>Patients First and Foremost</i>, the Government committed to draw up a new set of fundamental standards of care that will sit within the legal requirements that providers of health and adult social care must meet to be registered with the Care Quality Commission.</p> <p>More needs to be done to involve people in their own care and therefore statutory guidance for clinical commissioning groups on involving patients in planning services</p>	
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239	<p>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.</p>	<p>Accepted.</p> <p>Discharging patients where it is unsafe, because there is no care and support in place, is clearly a matter of clinical negligence and a breach of the duty of care that professionals have towards those they care for. The Department of Health can see few situations where it would be reasonable to discharge a patient at night, unless it was both safe and the express wish of the patient.</p> <p>The current guidance 'Ready to Go' sets out clear steps for local authorities and the NHS to work together to plan the safe and timely discharge of patients from hospital, or transfer of patients to another care setting. Strong multi-disciplinary discharge teams are vital to ensuring that patients are discharged in a safe and timely manner.</p> <p>The Government is committed to ensuring safe and timely discharges, and reducing unnecessary delays. We are supporting safe and timely discharges through spending £1 billion between 2010 and 2015 on reablement services which help people to regain their independence and confidence following discharge from hospital. In 2015–16 the £3.8 billion Integration Transformation Fund will bring health and social care commissioners together to plan services around people to improve outcomes and experiences.</p> <p>In its initial response to The Inquiry, <i>Patients First and Foremost</i>, the Government committed to draw up a new set of fundamental standards of care that will sit within the legal requirements that providers of health and adult social care must meet to be registered with the Care Quality Commission.</p> <p>In June 2013, the Care Quality Commission issued <i>A new start – Consultation on changes to the way Care Quality Commission regulates, inspects and monitors care</i>. This document started the public discussion on what the fundamental standards of care should be.</p> <p>The Department of Health has issued draft regulations for consultation, which set these fundamental standards of care in legislation as outcomes that must be avoided, as well as streamlining and improving the clarity of requirements which must be positively achieved in order for a provider to register with the Care Quality Commission. The Care Quality Commission, through its Chief Inspector of Hospitals, is engaging with providers, professionals and the public on what guidance it should publish on complying with these regulations and how they should relate to the Care Quality Commission's broader assessments of the quality of hospital services. The new regulations setting out standards of care, and the Care Quality Commission's associated guidance for providers on them, will come into effect during 2014, subject to Parliamentary approval.</p> <p>Care Quality Commission inspectors will spend more time listening to patients, service users and the staff who care for them. They will also speak directly to</p>	<p>New Fundamental Standards regulations come into force for all providers of health and social care in April 2015. The new fundamental standards are:</p> <ul style="list-style-type: none"> • care and treatment must be appropriate and reflect service users' needs and preferences. • service users must be treated with dignity and respect. • care and treatment must only be provided with consent. • care and treatment must be provided in a safe way. • service users must be protected from abuse and improper treatment. • service users' nutritional and hydration needs must be met. • all premises and equipment used must be clean, secure, suitable and used properly. • complaints must be appropriately investigated and appropriate action taken in response. • systems and processes must be established to ensure compliance with the fundamental standards (good governance). • sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed. • persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed. • A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity (Duty of Candour). <p>Between April and June 2014, the Care Quality Commission consulted on how it planned to change the way it regulates, inspects and rate care services. The resulting changes will come into effect in April 2015 and consultation handbooks were issued for the seven types of provider: acute, mental health and community hospitals; NHS GP and out of hours services; residential, community and hospice adult social care services. The handbooks set out for each type of provider:</p> <ul style="list-style-type: none"> • what the Care Quality Commission look at on an inspection. • how the Care Quality Commission judge what 'good' care looks like. • how the Care Quality Commission rate care services to help people judge and choose care if they want to. • how the Care Quality Commission use information to help decide when and where to inspect.

		<p>senior managers and board members. Inspection will include a closer examination of records, and inspection visits at night and at weekends. The Chief Inspector and his inspectorate are committed to complete openness about where good and bad care is being delivered.</p> <p>fundamental</p>	
240	<p>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.</p>	<p>Accepted.</p> <p>In its initial response to The Inquiry, <i>Patients First and Foremost</i>, the Government committed to draw up a new set of fundamental standards of care that will sit within the legal requirements that providers of health and adult social care must meet to be registered with the Care Quality Commission.</p> <p>In June 2013, the Care Quality Commission issued <i>A new start – Consultation on changes to the way Care Quality Commission regulates, inspects and monitors care</i>. This document started the public discussion on what the fundamental standards of care should be.</p> <p>The Department of Health has issued draft regulations for consultation, which set these fundamental standards of care in legislation as outcomes that must be avoided, as well as streamlining and improving the clarity of requirements which must be positively achieved in order for a provider to register with the Care Quality Commission. The Care Quality Commission, through its Chief Inspector of Hospitals, is engaging with providers, professionals and the public on what guidance it should publish on complying with these regulations and how they should relate to the Care Quality Commission's broader assessments of the quality of hospital services. The new regulations setting out fundamental standards of care, and the Care Quality Commission's associated guidance for providers on them, will come into effect during 2014, subject to Parliamentary approval. The final set of standards is likely to cover areas such as: care and safety of patients and service users; abuse, including neglect; respecting and involving service users; nutrition; consent; governance; cleanliness and safety of premises and equipment; staffing; fitness of directors; and duty of candour.</p> <p>Local Healthwatch organisations are using their 'enter and view' powers to get a clear picture of how health and care services are meeting the needs of the public, and their place on every local health and wellbeing board will ensure that voices of people using services is at the heart of local planning and decision-making. Local Healthwatch will also enhance the new inspection regimes. They will make sure inspection teams get a comprehensive picture of local people's opinions and concerns, and will maintain a focus on service quality issues after the inspection team has moved on.</p> <p>In April 2013, a new system of Patient-led Assessment of the Care Environment was introduced. This annual inspection is carried out by teams including at least 50% patients or members of the public. It includes an assessment of visible cleanliness and prompts an action plan to address any shortcomings.</p> <p>Furthermore, <i>The Code of Practice on the Prevention and Control of Infections and Related Guidance</i> (2010) sets out the ten criteria against which registered providers will be judged on how it complies with the registration requirement for cleanliness and infection control, although not all criteria will apply to every regulated activity. Currently, registered providers need to demonstrate to the Care Quality Commission that they have systems in place to manage and monitor the prevention and control of infection, which includes providing and maintaining a clean and appropriate environment.</p> <p>Part of a Trust Board's work to focus its organisation around patient safety will include demonstrating behaviours that instil a culture of openness and learning,</p>	<p>The Care Quality Commission has 11 new fundamental standards will come in to force for all providers in April 2015. These new regulations are clearer statements of the standards below which care should never fail. One of these standards is 'cleanliness, safety and suitability of premises and equipment'.</p>

		<p>where junior members of staff feel able to challenge their senior colleagues, and those in authority react appropriately.</p>	
241	<p>The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.</p>	<p>Accepted.</p> <p>In its initial response to The Inquiry, <i>Patients First and Foremost</i>, the Government committed to draw up a new set of fundamental standards of care that will sit within the legal requirements that providers of health and adult social care must meet to be registered with the Care Quality Commission.</p> <p>In June 2013, the Care Quality Commission <u><i>A new start – Consultation on changes to the way CQC regulates inspects and monitors care</i></u>. This document started the public discussion on what the fundamental standards of care should be.</p> <p>The Department of Health has issued draft regulations for consultation, which set these fundamental standards of care in legislation as outcomes that must be avoided, as well as streamlining and improving the clarity of requirements which must be positively achieved in order for a provider to register with the Care Quality Commission. The Care Quality Commission, through its Chief Inspectors, is engaging with providers, professionals and the public on what guidance it should publish on complying with these regulations and how they should relate to the Care Quality Commission's broader assessments of the quality of services. The new regulations setting out fundamental standards of care, and the Care Quality Commission's associated guidance for providers on them, will come into effect during 2014, subject to Parliamentary approval. The final set of standards is likely to cover areas such as: care and safety of patients and service users; abuse, including neglect; respecting and involving service users; nutrition; consent; governance; cleanliness and safety of premises and equipment; staffing; fitness of directors; and duty of candour. Local Healthwatch organisations are using their 'enter and view' powers to get a clear picture of how health and care services are meeting the needs of the public, and their place on every local health and wellbeing board will ensure that voices of people using services is at the heart of local planning and decision-making. Local Healthwatch will also enhance the new inspection regimes. They will make sure inspection teams get a comprehensive picture of local people's opinions and concerns, and will maintain a focus on service quality issues after the inspection team has moved on.</p> <p>The Department of Health is awarding grant funding to the Malnutrition Taskforce, led by Age UK, to run stage 1 of a pilot programme to test a framework to reduce malnutrition among older people in a range of health and care settings. The Malnutrition Taskforce's pilot will bring together the relevant professionals from a range of care settings, to work together to improve the care of older people at risk of malnutrition, raise awareness to help prevent people becoming malnourished in the first place, and help carers and clinicians identify and treat people with malnutrition more effectively.</p> <p>The Malnutrition Taskforce have published a series of <u>guides</u> offering expert advice on the prevention and early intervention of malnutrition in later life. These guides draw together principles of best practice to offer a framework developed to help those in a wide range of health and care settings make the changes needed to counter malnutrition. The <u>guides</u> are available.</p> <p>Trusts are encouraged to implement <u>Protected Mealtimes</u> which the National Patient Safety Agency issued guidance on in 2007. Shifts should be organised so that staff are not taking breaks at the same time as patients are being served meals, to ensure that staff are available at mealtimes to help patients eat and drink – this is particularly important for older patients and people with dementia.</p>	<p>The Department of Health is working with Age UK and funding a programme of work, which will help to reduce malnutrition among older people within hospitals, in other care settings and their homes. This work is also part of a wider programme of actions initiated by this Government that will improve the care of older people – fundamental standards of care, below which care should never fall; improving and enabling nurse leadership; and embedding a caring culture that prioritises the quality of care.</p> <p>The Department of Health granted funding to the Malnutrition Taskforce, led by Age UK, to run a pilot programme to test a framework to reduce malnutrition among older people in a range of health and care settings. Stage 1 of this pilot scheme ran from October 2013 and completed at the end of March 2014 and stage 2 will run from April 2014 to March 2015.</p> <p>The Malnutrition Taskforce proposal aims to test and evaluate a collaborative, supported change management programme and then to extract the learning and disseminate it across England, with the overall objective of reducing malnutrition among older people, within hospitals, other care settings and their own homes. The Malnutrition Taskforce is an independent group of experts, formed with the aim of reducing the prevalence of malnutrition and dehydration among older people. The Taskforce is co-chaired by Dianne Jeffrey (Chair of Age UK) and Dr Mike Stroud (consultant gastroenterologist and Chair of the British Association for Parental and Enteral Nutrition). The group includes providers and commissioners of health and social care, older people and carers, academics, professionals and the industry.</p> <p>In the first phase of its work, the Taskforce engaged with experts, frontline professionals, older people and carers to rigorously evaluate evidence to develop a number of best practice approaches and a framework designed to help make the changes needed to counter malnutrition among older people. There was good progress of the programme against the proposals originally submitted to the Department and Age UK has confirmed that the milestones for stage 1 of the programme were achieved. This included:</p> <ul style="list-style-type: none"> • two pilot sites established in Lambeth/Southwark and Salford; • the change management programme underway in the two sites; • Programme Steering Group established, which meets quarterly; and • qualitative research carried out among older people, carers and healthcare professionals to inform development of the marketing messages; <p>Stage 2 of the programme includes:</p> <ul style="list-style-type: none"> • refinement and continuation of the change management programme and social marketing campaign plus extension of the programme and campaign to three further areas; • engagement of community networks to continue local dissemination of learning following the end of the programme; • communications to spread learning across public and professional networks, including online and social media; and • three regional, professional-facing events to showcase learning and share good practice. <p>Currently Age UK is on target to provide the final evaluation report at the end of the programme in March 2015.</p> <p>The Department of Health established the Hospital Food Standards Panel to examine the variation in the quality of hospital food and drink across the country. The Panel recommended that all NHS hospitals develop and maintain a food and drink strategy which should include how it will address the nutritional care of</p>

			<p>patients. They recommended that this will be monitored through the annual Patient-led Assessments of the Care Environment and that it should be enhanced to take account of this and enable a more detailed evaluation of hospital food. The Department of Health has begun working with NHS England and the Health and Social Care Information Centre to take this forward</p>
242	<p>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.</p>	<p>In the initial Government response to The Inquiry, <i>Patients First and Foremost</i>, the Department of Health gave strong support to supervisory roles for Ward Managers (including Sister, Charge Nurse and Team Leader) in delivering oversight to all aspects of care on a ward and in a community, from cleanliness to allocation of staff. Nurse leadership at ward level provided by a Ward Manager is also important to the delivery of safe, high-quality care to patients. However, we wish to allow for local flexibility in delivering nursing care and so the Government is not mandating that ward nurse managers must operate in a supervisory capacity. Having sufficient nurses trained and with the capacity to ensure the delivery of safe, patient focused care is currently a core standard requirement of the Care Quality Commission. <i>Compassion in Practice</i>, the vision and strategy for nursing in England, commits to ensuring we have the right staff, with the right skills in the right place. This includes supporting leaders to be supervisory, giving them time to lead action plans by December 2013.</p> <p>In <i>Patients First and Foremost</i>, the Government committed to draw up a new set of fundamental standards of care that will sit within the legal requirements that providers of health and adult social care must meet to be registered with the Care Quality Commission.</p> <p>In June 2013, the Care Quality Commission issued <i>A new start – Consultation on changes to the way Care Quality Commission regulates, inspects and monitors care</i>. This document started the public discussion on what the fundamental standards of care should be.</p> <p>The Department of Health has issued draft regulations for consultation, which set these fundamental standards of care in legislation as outcomes that must be avoided, as well as streamlining and improving the clarity of requirements which must be positively achieved in order for a provider to register with the Care Quality Commission. The Care Quality Commission, through its Chief Inspector of Hospitals, is engaging with providers, professionals and the public on what guidance it should publish on complying with these regulations and how they should relate to the Care Quality Commission's broader assessments of the quality of hospital services. The new regulations setting out fundamental standards of care, and the Care Quality Commission's associated guidance for providers on them, will come into effect during 2014, subject to Parliamentary approval. The final set of standards is likely to cover areas such as: care and safety of patients and service users; abuse, including neglect; respecting and involving service users; nutrition; consent; governance; cleanliness and safety of premises and equipment; staffing; fitness of directors; and duty of candour.</p> <p>Local Healthwatch organisations are using their 'enter and view' powers to get a clear picture of how health and care services are meeting the needs of the public, and their place on every local health and wellbeing board will ensure that voices of people using services is at the heart of local planning and decision-making. Local Healthwatch will also enhance the new inspection regimes. They will make sure inspection teams get a comprehensive picture of local people's opinions and concerns, and will maintain a focus on service quality issues after the inspection team has moved on.</p> <p>Administration of medicines is one part of a system in hospitals designed to ensure patients have safe and effective access to the medicines they need. Other components of that system include safe prescribing and supply of medicines. The Nursing and Midwifery Council's Standards for Medicines Management sets</p>	<p>The Care Quality Commission has 11 new fundamental standards will come in to force for all providers in April 2015. These new regulations are clearer statements of the standards below which care should never fail. One of these standards is 'safe care and treatment' which specifically outlines the need to protect service users from avoidable harm through the control and management of medications.</p>

		<p>standards for safe practice in the management and administration of medicines expected of registered nurses, midwives and specialist community public health nurses. The General Medical Council's guidance <i>Good practice in prescribing and managing medicines and devices</i> sets out expectations of registered medical practitioners. The General Pharmaceutical Council sets standards for registered pharmacists and registered pharmacy technicians. All of these members of the local clinical team contribute to safe use of medicines in an organisation.</p> <p>However, the Royal Pharmaceutical Society's <i>Professional Standards for Hospital Pharmacy Services</i> makes clear that the hospital chief pharmacist (or equivalent) leads on ensuring that all aspects of medicines use within its organisation are safe. Therefore local hospital pharmacy teams must ensure systems are in place to minimise risks to patients from medicines, and working with doctors, nurses and management colleagues, ensure those systems are robustly and regularly monitored and audited. Importantly, local organisations must also encourage a culture and system which supports reporting and learning from medication mistakes and errors. Such systems and processes must be set out in local hospital medicines policies, signed off by the hospital Trust Board, with the board receiving regular reports (eg annually) on implementation and areas for improvement, together with remedial action plans.</p> <p>On occasion it is necessary for nurses to withhold medicines from administration. For example, when some medicines need to be temporarily halted before surgery, or is the registered nurse considers that administration of the prescribed medicine or dose would put the patient at risk.</p> <p>The Government's <i>Information Strategy</i>, published in May 2012, outlined several elements which will be applicable to the administration of medicines. The Department will continue to collaborate with key partners such as the National Care Forum, the Royal Pharmaceutical Society and key Royal Colleges, building on existing work, to improve the use of medicines in care homes, including considering the role of technological innovation and commissioning incentives in transforming safety and efficiency.</p> <p>The Department of Health also set out in <i>Transforming Care: a national response to Winterbourne View Hospital</i> a number of actions to address concerns raised about the prescription and administration of medications, including the overuse of anti-depressants and anti-psychotics for individuals with mental health conditions, learning disabilities, autism or behaviour that challenges and the use of rapid tranquilisation to restrain patients in crisis. The Department of Health is currently leading a cross-Governmental review of the Mental Health Act 1983 Code of Practice. This will include updating current guidance on the use of medications for individuals subject to the Mental Health Act. We will consult on a revised Code early in the New Year.</p> <p>NHS England is also leading a review on the use of medications for individuals with a learning disability or behaviour that challenges. Working with NHS Improving Quality, NHS England is developing proposals for a collaborative to highlight and share best and safe practice in the prescribing, administration, dispensing and use of medications for individuals with a learning disability or behaviour that challenges. The proposals for the collaborative are currently being finalised and it will be launched shortly.</p>	
243	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this	<p>Accepted.</p> <p>In the initial Government response to The Inquiry, <i>Patients First and Foremost</i>, the Department of Health gave strong support to supervisory roles for Ward Managers (including Sister, Charge Nurse and Team Leader) in delivering oversight to all aspects of care on a ward and in a community, from cleanliness to allocation of staff.</p>	<p>In the first round of the Nursing Technology Fund, 74 Trusts were awarded funding totalling almost £30m for 85 projects.</p> <p>The funded projects represent a good geographical spread and a range of care settings. The highest award to an individual project was £1 million, and to an individual organisation was £1.46 million (for two separate projects). All projects</p>

	<p>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.</p>	<p>Nurse leadership at ward level provided by a Ward Manager is also important to the delivery of safe, high-quality care to patients. However, we wish to allow for local flexibility in delivering nursing care and so the Government is not mandating that ward nurse managers must operate in a supervisory capacity.</p> <p>Having sufficient nurses trained and with the capacity to respond to ensure the delivery of safe, patient focused care is currently a core standard requirement of the Care Quality Commission. <i>Compassion in Practice</i> commits to ensuring we have the right staff, with the right skills in the right place. This includes supporting leaders to be supervisory, giving them time to lead action plans by December 2013.</p> <p>The <u>Government's Information Strategy</u>, published in May 2012, outlines the use of routine observations in improving the quality of data saying: 'Connected information can support safer, more integrated care for us and for the professionals providing our care— for example, through online access to GP records in hospitals, electronic prescriptions, barcode-scanning in care homes and hospitals to reduce medication errors, and electronic access to results, X-rays and scans. Many benefits and efficiencies can be achieved through information being recorded once, at first contact, and shared securely between those providing our care.'</p> <p>In October 2012 the Prime Minister announced the Nursing Technology Fund, an investment fund of £100 million spread over 2013–14 and 2014–15. Three key technology types have been identified: digital pens, mobile technology and, of relevance to this recommendation, end of bed monitoring technologies. Full details of how NHS providers will be able apply for funding are to be announced shortly. The Nursing Technology Fund is available to support nurse or midwife led activity in all NHS Trusts and Foundation Trusts in England, including acute, community, mental health and ambulance trusts.</p> <p>Local Healthwatch organisations are using their 'enter and view' powers to get a clear picture of how health and care services are meeting the needs of the public, and their place on every local health and wellbeing board will ensure that voices of people using services is at the heart of local planning and decision-making. Local Healthwatch will also enhance the new inspection regimes. They will make sure inspection teams get a comprehensive picture of local people's opinions and concerns, and will maintain a focus on service quality issues after the inspection team has moved on.</p>	<p>projected a Value For Money return greater than 2:1, with almost half projecting a return of at least 4:1. Of the successful projects, 90% will provide solutions for nurses, 23% for midwives, and 10% for health visitors. The majority of projects involve mobile technology, a quarter involve vital signs monitoring solutions, and eight projects involve digital pens.</p>
244	<p>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:</p> <ul style="list-style-type: none"> • 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 	<p>Accepted.</p> <p>There is both a need for common information practices that support the extraction of data to central systems to support improvements in data quality and service provision, and a need for electronic patient systems.</p> <p>The <u>Health and Social Care Act 2012</u> gives the Secretary of State for Health and NHS England powers to publish, or adopt, data standards that specify how data should be processed. To support this work the Health and Social Care Information Centre also publishes performance information and statistics, using transparent calculations, so that they can be used across the health and care system. The Health and Social Care Information Centre's <u>Indicator Portal</u> which will extend this service.</p> <p>Access to the summary care record is being rolled out across England and we will assess options for making them more accessible electronically.</p> <p>We also agree that patients should have access to their own records. By spring 2015 every patient will be able to see their records, test results, book appointments and order repeat prescriptions online. See <u>Everyone Counts: Planning for Patients 2013–14</u> (NHS England, December 2012). Patients will also be able to communicate with</p>	<p>Access to the Summary Care Record is progressing well with just over 40 million records available and NHS England is leading work to ensure a third of Accident and Emergency Services, 111 Services and Ambulance Services will have access to Summary Care Records by 2015. NHS England's business plan for 2014/15 - 2016/2017 also outlines a key deliverable that online access to GP records would be available in 95% of GP practices from March 2015.</p> <p>The timescales for an NHS England Technology Strategy have been impacted by the development of a National Information Board Framework which covers the whole of the health and care system and all of the arms-length bodies. The criticality of NHS number and delivery via a standards-based approach to enable interoperability and exchange of data is pivotal in the <u>National Information Board Framework</u>, which was published in November. NHS England will then publish its Technology and Data Strategy for which the use of NHS Number and a standards-based approach will again be vital.</p> <p>The intention is to put citizens in control of the decisions about their own healthcare and how they access services, be it online access to their medical record; online booking of services e.g. appointments and repeat prescriptions and access to trusted NHS "apps" and social networks.</p>

	<p>contribute to safe and effective care, and to accurate recording of information on first entry.</p> <ul style="list-style-type: none"> • 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. <p>Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.</p>	<p>their practice electronically as outlined in <i>The Power of Information</i> (Department of Health, May 2012).</p> <p>While we expect practices to make patients' records available online as fully possible, some practices will only be able to make records available from a specific date due to the way the records were stored originally.</p> <p>The Department of Health is committed to connecting existing systems rather than expecting every organisation to use the same technology, see <i>Liberating the NHS: An Information Revolution</i> (Department of Health, July 2010) and <i>The Power of Information</i> (Department of Health, May 2012). As such, GP practices will set specific requirements for electronic patient records locally, based on national standards to ensure that information can be shared across the system. As such it is for local organisations to consider the substance of the points raised in this recommendation in that light.</p> <p>Some national standards have already been set, including the use of the NHS number, and further standards will be included in NHS England's Technology Strategy, which is due to be published in early 2014.</p> <p>As part of NHS England's publication <i>Safer Hospitals, Safer Wards: Achieving an Integrated Digital Care Record</i> (July 2013) it announced a £260 million technology fund that can be used by NHS Foundation Trusts and NHS Trusts to progress their activities to replace paper based systems for patient notes with integrated digital care records. NHS organisations can also apply for funding to support them improve efficiency, quality and safety by introducing ePrescribing systems.</p>	
245	<p>Each provider organisation should have a board level member with responsibility for information.</p>	<p>Accepted in principle.</p> <p>Boards must have both reliable intelligence to support the delivery of high quality care and the skills and training needed to use that intelligence appropriately.</p> <p>While it is for Trusts to agree the roles and responsibilities of individual Board members locally, in line with this recommendation the Department of Health supports:</p> <ul style="list-style-type: none"> • the NHS Leadership Academy who set out clear roles for Executive Directors in taking '<i>... principal responsibility for providing accurate, timely and clear information to the board</i>' as part of <i>The Healthy NHS Board</i> (NHS Leadership Academy, 2013); and • forums such as the Chief Clinical Information Officers Leaders Network, established by eHealth Insider, with the support of the Royal College of Physicians, to support doctors, nurses and allied health professionals who are taking the lead on information and its use within organisations. <p>The Department also support programmes that embed informatics within the work of non- board members including clinicians and staff. These include the Clinical Leaders Network's <i>Embedding Informatics in Clinical Education</i>, an online tool to train about the use of informatics in clinical work.</p> <p>In addition, the Care Quality Commission's new inspection process includes an assessment of whether a provider is well led. In <i>A New Start</i> (Care Quality Commission, July 2013) they stated that 'well led' providers will have effective leadership that listens and learns from information about services such that they are able to have open discussions about the quality of services that are evidence based.</p>	<p>This recommendation is aimed at provider organisations and the response is unchanged.</p>

		The Care Quality Commission will start inspecting all acute service providers from 2014 using this new process.	
246	Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.	<p>Accepted.</p> <p>While Quality Accounts provide information about local providers' performance, and should be flexible enough to support reporting at that level, they should also contain key information, in a common form, that allows direct comparisons to be made. This includes information on compliance with basic requirements and performance on key metrics including a set of outcome statistics.</p> <p>The <u>National Health Service (Quality Accounts Regulations) 2010</u> the <u>National Health Service (Quality Accounts) Amendment Regulations 2011</u> and the <u>National Health Service (Quality Accounts) Amendment Regulations 2012</u> set out prescribed information that must be included within Part 2 of the Quality Accounts.</p> <p>This includes the following information:</p> <ul style="list-style-type: none"> • where the provider is subject to periodic review by the Care Quality Commission including: • the date of the most recent review; • the assessment made by the Care Quality Commission following the review; • the action the provider intends to take to address the points made in that assessment by the Care Quality Commission; and • any progress the provider has made in taking the action identified in the point above prior to the end of the reporting period. • the value and banding of the summary hospital level mortality indicator; and • other outcome measures including C. difficile per 100,000 bed days and the percentage of patients admitted to hospital who were risk assessed for venous thromboembolism. <p>In addition, NHS England will issue guidance in October 2013 to include the patient component of the friends and family test as part of these measures.</p> <p>In addition, the <u>National Health Service (Quality Accounts) Amendment Regulations 2012</u> require all Quality Accounts to include an annex that contains the statements of the:</p> <ul style="list-style-type: none"> • Overview and Scrutiny Committee or joint Overview and Scrutiny Committee carrying out the functions of that Overview and Scrutiny Committee; • relevant clinical commissioning group or NHS England where 50% or more of the relevant health services that the provider directly provides or sub-contracts during the reporting period are under contracts or arrangements with NHS England; and • local Healthwatch organisation. 	In response to the recommendation, there is now an area on NHS Choices providing presentational guidance. As part of the NHS England review of Quality Accounts (see Rec 37), it was recommended this should be further developed to include guidance about publishing data in a more patient friendly way. The Quality Accounts review has also identified the need to provide local Healthwatch organisations with guidance on how to effectively challenge local Quality Accounts. This is being taken forward by NHS England and Healthwatch with a view that this will help to inform Healthwatch comments on Quality Accounts in 2014/15
247	Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from	<p>Accepted.</p> <p>The <u>National Health Service (Quality Accounts Regulations) 2010</u> require that by</p>	All Quality Accounts have to be lodged with NHS Choices which is accessible to all stakeholders. The NHS England review of Quality Accounts (see Rec 37) has also recommended an improvement in the functionality of NHS Choices

	<p>them, Local Healthwatch, and all systems regulators.</p>	<p>30 June following the end of the reporting period, Quality Accounts must be published by making them electronically available on the NHS Choices website or another website if that website is not available at the time of publication.</p> <p>Prior to publication, and within 30 days of 1 April following the end of the reporting period, each provider is required to make a copy of the draft Quality Account available to the appropriate Local Healthwatch organisation, Overview and Scrutiny Committee and Clinical Commissioning Group.</p> <p>Where 50% or more of the relevant health services that the provider directly provides or sub- contracts during the reporting period are under contracts or arrangements with NHS England the provider must make the draft Quality Account available to NHS England rather than a Clinical Commissioning Group.</p>	<p>which has taken effect in 2014/15.</p>
248	<p>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.</p>	<p>Accepted.</p> <p>Quality accounts are independently audited by external auditors of Foundation and non- Foundation Trusts.</p> <p>For NHS Trusts, Directors of the Trust should take steps to assure themselves that their Quality Accounts comply with the requirements set out in the legislation governing Quality Accounts: Part 1 chapter 2 of the <i>Health Act 2009</i> and the <i>National Health Service (Quality Accounts Regulations) 2010</i> and the <i>National Health Service (Quality Accounts) Amendment Regulations 2012</i>. A statement of Directors' responsibilities confirming that these steps have been taken must be included in the Trust's published Quality Account. Monitor requires Foundation Trusts to obtain an audit opinion on their Quality Accounts, this includes an opinion that the contents of the Quality Accounts comply with regulations and also an opinion on selected indicators included in the accounts.</p> <p>Auditors also provide a signed limited assurance on a small number of indicators and provide assurance on the number of patient safety incidents that occurred within the Foundation Trust.</p> <p>The Trust must produce an Annual Governance Statement, the content of which is determined by the Trust, which refers to the steps taken to assure themselves that their Quality Account is reliable and accurate.</p> <p>In 2012–13 external assurance requires Foundation Trust auditors to:</p> <ul style="list-style-type: none"> • review the content of the Quality Report against the requirements set out in the <i>NHS Foundation Trust Annual Reporting Manual 2012–13</i> (Monitor, March 2013); • review the content of the Quality Report for consistency against the other information sources detailed in section 2.1 of this guidance; • provide a signed limited assurance report in the Quality Report on whether anything has come to the attention of the auditor that leads them to believe that the Quality Report has not been prepared in line with the requirements set out in the <i>NHS Foundation Trust Annual Reporting Manual 2012–13</i> (Monitor, March 2013) and is not consistent with the other information sources detailed in section 2.1 of this guidance; • undertake substantive sample testing on two mandated performance indicators, and the newly mandated safety incidents indicator, (to include, but not necessarily be limited to, an evaluation of the key processes and controls for managing and reporting the 	<p>The Quality Accounts review gave further consideration to the audit approach and how its remit might be extended. The skill set of the organisations and people currently auditing Quality Accounts is, in the main, financial. One area the evaluation was particularly keen to explore was how the role of audit could be expanded beyond the review of source documents into a more outcomes orientated process. National Clinical Audit was seen as a key enabler for this. Participation in National Clinical Audit is mandated through the NHS Standard contract, supports local quality improvement and enables individual clinicians or teams to benchmark themselves against accepted clinical guidelines and standards. Such an Audit also enables patients to question the quality of their care and exercise choice. National Clinical Audits are all supported by specialist methodological frameworks, are case mix risk adjusted where appropriate and will be reviewed through a Quality Assessment Framework. Consideration will be given to how the current outputs of National Clinical Audit could be included within the Quality Account to provide an audited view of clinical data sitting alongside the current mandated audit arrangement for 2014/15.</p>

		<p>indicators and sample testing of the data used to calculate the indicator back to supporting documentation);</p> <ul style="list-style-type: none"> • provide a signed limited assurance report in the Quality Report on whether there is evidence to suggest that the two mandated indicators subject to a limited assurance report have not been reasonably stated in all material respects in accordance with the <i>NHS Foundation Trust Annual Reporting Manual 2012–13</i> (Monitor, March 2013); and • provide a report (the Governors' Report) to the NHS Foundation Trust's council of Governors and Board of Directors of their findings and recommendations for improvements concerning the content of the Quality Report, the two mandated indicators, subject to a limited assurance report, the additional mandated indicator and any locally selected indicator(s), if applicable. <p>However, in addition to the information audited outlined above, Quality Accounts also include local information that is specific to the services, priorities and needs of patients locally. While this is useful information to report on within Quality Accounts it cannot be audited externally without considerable local knowledge. Instead, Quality Accounts are verified locally for their accuracy and a declaration is signed by order of the Board by the Chairman and the Chief Executive (see recommendation 249).</p> <p>We will review Quality Accounts before the 2014–15 cycle to ensure that they give patients appropriate information regarding the services they use, and that they add value to the quality assurance infrastructure used by trusts, local and national organisations. The review will consider whether the remit of the audit process could be extended further and will report in early 2014.</p>	
249	<p>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.</p>	<p>Accepted in part.</p> <p>The <i>National Health Service (Quality Accounts Regulations) 2010</i> state that Quality Accounts must include a '<i>...written statement... signed by the responsible person for the provider that to the best of that person's knowledge the information in the document is accurate...</i>' While this does not include a separate signature from each director, the Quality Account is signed as an accurate and reliable record on their behalf.</p> <p><i>2012–13 Detailed Guidance for External Assurance on Quality Reports</i> (Monitor, March 2013), states that for 2012–13 Foundation Trusts will be required to sign a Statement of Directors' Responsibilities in respect to the Quality Report that states that performance information reported in the Quality Report is reliable and accurate. This is signed by order of the Board by the Chairman and the Chief Executive.</p> <p><i>Quality Accounts: 2011–12 audit guidance</i> (Department of Health, April 2012) states that Trusts must sign a statement of Directors' responsibilities in respect of the content of their quality accounts. This includes a statement that, '<i>...the performance information in the Quality Account is reliable and accurate</i>'. This is signed by order of the Board by the Chairman and the Chief Executive.</p> <p>We will review Quality Accounts before the 2014–15 cycle to ensure that they give patients appropriate information regarding the services they use, and that they add value to the quality assurance infrastructure used by trusts, local and national organisations. While the review is yet to complete, we anticipate that NHS England will implement this recommendation and include it within guidance that it intends to issue by the end of March 2014. NHS England will advise Trusts of expected changes in early 2014 to support them to plan for the 2014–15 cycle.</p>	<p>The review of Quality Accounts has considered this recommendation. The review felt strongly about accountability and was clear that this could be better achieved by enabling Healthwatch to challenge Quality Accounts locally, given the existing requirements set out above. We will work with Healthwatch to develop guidance. We also intend for Quality Accounts to fall within the scope of the 'false and misleading information offence' and for the offence to apply for them. This should come into effect by winter 2014.</p> <p>The review also felt it was important for Quality Accounts to be made accessible to the public in a more patient friendly format. NHS England plan to issue guidance to support this in 2014/15.</p>

250	<p>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.</p>	<p>Accepted in principle.</p> <p>We will use the consultation on False or Misleading Information to consider whether the False or Misleading Information offence should be applied to the information on quality accounts.</p> <p>The Care Bill proposes a new offence where care providers give false or misleading information. This will give providers an additional incentive to ensure data and the information it provides are accurate. The offence will aid transparency and accountability in the provision of care so that regulators, commissioners and the public have a more accurate picture about a provider's performance. The offence will apply to those care providers that falsify certain types of management and performance information and fail to exercise due diligence. Providers that make a genuine administrative error would not be convicted, providing they have processes and procedures in place to demonstrate they took all reasonable steps and exercised due diligence.</p> <p>The offence will allow for the prosecution of directors and senior individuals, where the offence has been committed with their consent or connivance or through their neglect, and a successful prosecutions has been brought against the provider.</p> <p>Our current intention is that regulations will limit the application of this offence in the first instance to providers of NHS funded secondary care and, more specifically, to the patient level information on outpatient, elective and accident and emergency activity that they are required to provide to the Health and Social Care Information Centre. However, we intend to test and confirm our thinking through further consultation before draft regulations are laid.</p>	<p>The Care Act 2014 has put in place a new criminal offence applicable to care providers who supply, publish or otherwise make available certain types of information that is false or misleading, where that information is required to comply with a statutory or other legal obligation. This offence also applies to senior individuals in a provider organisation if they consent to or connive in the offence.</p>
251	<p>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.</p>	<p>Accepted in principle.</p> <p>Where inaccurate information is identified within a Quality Account it should be changed by the provider as soon as possible.</p> <p>While responsibility for the accuracy of the Quality Accounts rests with providers, their external auditors audit these accounts to provide limited assurance of their accuracy. Where issues are located the auditors provide the Board, and the Board of Governors where applicable, with a report of their findings along with recommendations for improvement (see recommendation 248). Where issues are identified as a result of the audit process the issues must be addressed by the provider. In all cases the report must be published as part of the provider's Quality Account.</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>
252	<p>It is important that the appropriate steps are taken to enable properly anonymised data to be used for managerial and regulatory purposes.</p>	<p>Accepted.</p> <p>For electronic patient records to become the core information used to improve care, services and to inform research as outlined in <i>The Power of Information</i> (Department of Health, May 2012) these records must be anonymised or used securely to protect patients' confidential information. Data also need to become more available, linked appropriately and of good quality. The Health and Social Care Information Centre set out its objectives for 2013–14 in its publication <i>Informing Better Care</i> (2013), in which it stated that it would take over data collection responsibilities from other bodies, extend its data linkage services and consolidate its position as a national source of indicators.</p> <p>A range of work has been taken forward already across the system to ensure that identifiable data is used appropriately. This includes, for example:</p> <ul style="list-style-type: none"> • the Health and Social Care Information Centre has set a new 	<p>The Department consulted on <i>Protecting personal health and care data</i> in June 2014. The consultation outlines proposals to improve how an individual's health and care data is shared across the National Health Service and the social care system.</p> <p>The consultation set out proposals for new regulations to place strong controls around the disclosure of data which might potentially identify individuals by the Health and Social Care Information Centre and accredited safe havens. The consultation also covered proposals for new regulations to address concerns about restrictions on the sharing of confidential personal information with NHS and social care case managers, who need to have access to this information in relation to those for whom they are responsible for arranging health or care services. The consultation closed on 08 August 2015 - the Department of Health is considering the responses received as the government decides how to respond to the consultation.</p>

		<p>anonymisation standard, from April 2013, that provides an approach and a set of standard tools to anonymise information to ensure that, as far as it is reasonably practicable, information published does not identify individuals;</p> <ul style="list-style-type: none"> recent guidance published by NHS England <i>Information Governance and Risk Stratification: Advice and Options for clinical commissioning groups and GP</i> (June 2013) advises clinical commissioning groups on the use of data for predictive modelling purposes. Further approvals are being put in place to ensure that the new commissioning organisations and structures are using Patient Confidential Data appropriately; the Health and Social Care Information Centre publications process allows pre-publication access to many of its statistics, mostly in aggregated form, for management purposes; the Health and Social Care Information Centre's Hospital Episode Statistics data service and linkage service facilitate the provision of data for managerial and regulatory purposes; and the use of anonymised data by the Clinical Practice Research Datalink, working with the Health and Social Care Information Centre, in research using linked anonymised data, to improve and safeguard public health. The <i>Government's response to the Caldicott Review</i> (Department of Health, September 2013) concluded that, '...the research community has established many good practices and developed robust solutions to enable access to detailed patient information while ensuring that confidentiality is protected'. <p>We will continue to support this area and, specifically:</p> <ul style="list-style-type: none"> the Health and Social Care Information Centre will publish its <i>Code of Practice for the Management of Confidential Information</i> later this year outlining principles for managing confidential data that all NHS bodies must comply with. This will build on <i>A Guide to Confidentiality in Health and Social Care</i> (Health and Social Care Information Centre, September 2013). The Code will also clarify patients' rights to know how data about them is being used and to object to the Health and Social Care Information Centre having access to that data should they wish to as outlined in <i>Information: To share or Not to Share</i> (Department of Health, March 2013); the Health and Social Care Information Centre, commissioned by NHS England, will make information from Care.Data available to commissioners and providers, in anonymised or aggregated form, to support the development of integrated services for patients; and 	<p>A consultation on the draft <i>Code of Practice for the Management of Confidential Information</i> closed on 18 August 2014. The Health and Social Care Information Centre will be considering the responses to the consultation in the formation of the Code of Practice.</p> <p>Availability of the Care.data programme to commissioners and providers was put on hold in order for there to be a longer period of engagement and consultation and discussion about access to data about individuals. Engagement work is ongoing, and as a result no data has yet been made available through Care.data programme.</p>
253	<p>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</p>	<p>Accepted.</p> <p>The Care Quality Commission is developing a new approach to inspection, and has started routinely publishing for the NHS the information that it uses to focus its inspections. This information is based on monitoring a set of indicators of risk, which have replaced the former quality and risk profile approach. As the Care Quality Commission carries out each inspection under its new approach, it will publish a data pack at the same time as publishing the inspection report. A data pack is a detailed analysis of key information that the Care Quality Commission holds about a provider, including its performance on risk indicators, other sources of data, and qualitative information such as views of local organisations and feedback from patients.</p> <p>In June 2013, the Care Quality Commission issued <i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i> This set out the new approach to inspecting hospitals, and sought views on an annex with the</p>	<p>The Care Quality Commission has replaced its Quality and Risk Profile with a system of Intelligent Monitoring to help decide when, where and what to inspect. This draws information and data from a range of sources to identify providers and services where there may be a greater risk of providing poor care. The evidence from the Intelligent Monitoring system is used to prioritise which providers will be inspected and the lines of enquiry during an investigation. The system triggers a response, for example, where there are a statistically significant number of severe harm incidents or avoidable deaths at a provider. "Never events" trigger an automated elevated risk in Intelligent Monitoring which inspectors follow up individually. The data it looks at includes information from:</p> <ul style="list-style-type: none"> Staff Patient surveys Mortality rates Hospital performance information such as waiting times and infection rates

		<p>full set of indicators that the Care Quality Commission proposed for monitoring hospitals, to identify potential risks and the priority order for inspection. On 24 October 2013 the Care Quality Commission published a full analysis of all its monitoring indicators for all acute hospital trusts, showing their performance against the indicators. The results of this intelligent monitoring work group, the 161 acute NHS trusts into six bands based on the risk that people may not be receiving safe, effective, high quality care – with band 1 being the highest risk and band 6 the lowest. The Care Quality Commission has undertaken to update and publish these analyses quarterly, with explanation of what should and should not be read into them. *Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well-led?</p>	<p>In October 2013, the Care Quality Commission began a pilot of its Intelligent Monitoring programme for acute and specialist NHS trusts. The pilot looked at more than 150 different sets of data (indicators), which related to the five key questions the Care Quality Commission asks of all services – are they safe, effective, caring, responsive, and well-led? Using this data, the Care Quality Commission grouped all acute NHS trusts into six priority bands for inspection. In March and July 2014, the Care Quality Commission updated its <u>surveillance model for acute and specialist NHS trusts</u>.</p> <p>In November 2014, the Care Quality Commission published Mental Health intelligent monitoring reports, which display the results of its analysis of Tier 1 indicators for all Mental Health NHS trusts. Each trust will receive an individual report and banding, similar to those for acute hospitals. The bandings will range from one to four.</p> <p>In November 2014 the Care Quality Commission published its first round of Intelligent Monitoring for GPs</p> <p>The Care Quality Commission has always used important information in statutory notifications as an indicator of quality and safety in the adult social care sector, alongside other information about safeguarding alerts and information provided by others such as people who use services, staff and the public. The Care Quality Commission does not have a lot of quantitative data consistently collected across the sector but it is taking steps to improve this. With a new, more thorough model, the Care Quality Commission intends to use all the available information to check whether there is a risk that services do not provide either safe or quality care.</p> <p>Draft Intelligent Monitoring models for the Adult Social Care sector have been in place since October 2014, with separate sets of indicators for residential, community and hospice services. the Care Quality Commission will continue to develop these models with providers and stakeholders to develop a more robust Intelligent Monitoring system within Adult Social Care during 2015/16 and beyond</p>
254	<p>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.</p>	<p>Accepted.</p> <p>Feedback from patients, carers and the public can be made on the quality of care through a range of technologies and channels including online, via bedside televisions, surveys and the friends and family test.</p> <p>The NHS Constitution (26 March 2013) pledges that the NHS will encourage and welcome feedback on your health and care experiences and use this to improve services. Similarly, <u>The Mandate</u> for NHS England (Department of Health, November 2013) states that NHS England will consider how to make it easier for patients and carers to give feedback and see reviews by other people so that timely, easy to review feedback on NHS Services becomes the norm.</p> <p>A number of organisations already exist that enable patients, carers and the public to provide online feedback about their care. This includes, but is not limited to, Patient Opinion, NHS Choices, Good Care Guide and iWantGreatCare. NHS England will make such comments accessible in a coherent and consistent way through NHS Choices.</p>	<p>Ensuring that patients, carers and the public can give feedback on the quality of care is an on-going commitment. The <u>2014-15 NHS Mandate</u> sets out how there will be rapid progress in measuring and understanding how people really feel about the care they receive and taking action to address poor performance.</p> <p>In July 2014 NHS England published a <u>Review of the Friends and Family Test</u> which found that Friends and Family Test is performing well as a service improvement tool, with 85% of trusts reporting that it is being used to improve patient experience, and 78% saying that Friends and Family Test has increased the emphasis placed on patient experience in their trusts. In particular, the open-ended follow-up question is proving a rich source of patient views at ward and Accident and Emergency departmental level that can be used, where implemented, to highlight best practice and identify and address concerns. NHS England is working with NHS Choices to look at ways to enhance the presentation and profile of the Friends and Family Test data for patients and the public to use.</p> <p>A number of organisations already enable patients, carers and the public to provide online feedback about their care. NHS England will make such comments accessible through a new national Health & Social Care Digital Service, which will be replacing NHS Choices. The new online service will bring together the most reliable and relevant data from national web services and act</p>

			<p>as a 'front door' to the best information on health and social care on the internet.</p> <p>Results from the Friends and Family Test are published monthly in all acute inpatient services, Accident and Emergency and in maternity.</p> <p>The first set of Friends and Family Test results from NHS staff were published in September. The Friends and Family Test was rolled out in general practice, community and mental health services by December 2014 and is on track to be rolled out in the remainder of NHS services as appropriate by March 2015. So far more than 5 million Patient Friends and Family Test responses have been collected; 4.5 million responses have been collected from Accident and Emergency and inpatients, and more than 551,000 from maternity patients. The second Staff Friends and Family Test was run from July to September 2014 and more than 141,000 staff from 242 service providers submitted Staff Friends and Family Test responses.</p>
255	<p>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.</p>	<p>Accepted.</p> <p>Many local Trusts are devising innovative ways to take this forward. Feedback from patients, carers and the public can be made on the quality of care through a range of technologies and channels including online, via bedside televisions, surveys and the friends and family test.</p> <p>The <u>NHS Constitution</u> (Department of Health, March 2013) pledges that the NHS will encourage and welcome feedback on your health and care experiences and use this to improve services. Similarly, <u>The Mandate</u> (Department of Health, November 2013) states that NHS England will consider how to make it easier for patients and carers to give feedback and see reviews by other people so that timely, easy to review, feedback on NHS Services becomes the norm.</p> <p>The friends and family test is currently in use in all acute inpatient services, Accident and Emergency and in maternity. By December 2014 it will be rolled out to general practice, community and mental health services and the remainder of NHS services by the end of March 2015. The test asks all patients in acute inpatients and Accident and Emergency if they would recommend the care they have just received to their friends and family if they needed similar care or treatment. The results are published for every ward and every Accident and Emergency department and in real time – within a maximum of five weeks after the feedback was collected. From ward to Board, staff and managers are able to look at the results of the friends and family test, see areas of strength and weakness and take appropriate action. Patients, the public and commissioners can see where scores are good and less good and use the results to hold services to account and commission for improvement.</p> <p>A number of organisations already exist that enable patients, carers and the public to provide online feedback about their care. This includes, but is not limited to, Patient Opinion, NHS Choices, Good Care Guide and iWantGreatCare.</p> <p>NHS England will make such comments accessible in a coherent and consistent way through NHS Choices and, from November 2013, as part of a national Health and Social Care Digital Service that will begin to bring together the most reliable and relevant data from national web services and act as a 'front door' to the best information on health and social care on the internet.</p> <p>The Government's <i>Information Strategy</i> outlined that patient feedback and information on patient experience will be an even more important influence on shaping policy and the delivery and regulation of care services. Involving people in decisions about their health, care and services should be the norm, not the exception.</p> <p>In the long term, electronic health and care records may prove to be a main vehicle</p>	<p>Results from the Friends and Family Test are published monthly in all acute inpatient services, Accident and Emergency and in maternity. In July NHS England published a <u>Review of the Friends and Family Test</u> and <u>Guidance</u> to support rollout of the Friends and Family Test in other NHS settings. The review found that 85% of Trusts are using the Friends and Family Test to improve patient experience and 78% report that it has increased the emphasis placed on patient experience in their Trusts. The <u>research</u> undertaken amongst staff groups demonstrates that rapid feedback of scores and comments to ward managers and nurses results in a number of positive outcomes.</p> <p>The first set of Friends and Family Test results from NHS staff were published in September. The Friends and Family Test was rolled out in general practice, community and mental health services by December 2014 and is on track to be rolled out in the remainder of NHS services as appropriate by March 2015.</p> <p>So far more than 5 million Patient Friends and Family Test responses have been collected; 4.5 million responses have been collected from Accident and Emergency and inpatients, and more than 551,000 from maternity patients. The second Staff Friends and Family Test was run from July to September 2014 and more than 141,000 staff from 242 service providers submitted Staff Friends and Family Test responses.</p>

		<p>for providing information on health and care outcomes and status, rating our experience of care, and leaving feedback and comment. Innovations linked to our online records could enable us to record and share health comments and also prompt better conversations between us as patients or users of services and the professionals providing our care.</p>	
256	<p>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.</p>	<p>Accepted.</p> <p>A good trust will take every opportunity to seek patient feedback. A good complaints system will recognise that some people will give fuller feedback once they have had time to reflect and therefore it is worth making arrangements to follow-up with patients once they have been discharged. Trusts will need to work out how they do this. The Care Quality Commission will be assessing complaints as part of its inspection process.</p> <p>Case study: Northumbria Healthcare – developing a meaningful patient experience programme</p> <p>Northumbria Healthcare NHS Foundation Trust provides acute and community health services and adult social care to a population of over half a million people in the North East. The Trust runs nine hospitals (three general hospitals plus six community hospitals) and employs about 9000 staff. The level of engagement they now enjoy means that every day, somewhere in the organisation, somebody will be having a conversation about patient experience.</p> <p>The Trust listens to the views of more than 30,000 patients every year through the following different survey methods:</p> <ul style="list-style-type: none"> • Patient Perspective surveys: To ensure ownership, results are reported at an individual consultant level, ward level, site and specialty and business unit level. Conducting these once people leave hospital allows them to give a more rounded view of their experience of care – evidence suggests that patients are likely to be at their most dissatisfied two weeks after discharge. In many ways this is 'right time' data which is less likely to be biased by the gratitude people feel towards hospital services and staff during the very acute phase. • Real Time Surveys: Initially the Trust conducted face to face interviews with patients on 8 pilot wards across 2 sites. The real time programme has been rolled out incrementally allowing the Trust to improve in a sustainable way – they now interview over 500 patients a month across 7 sites and 35 wards. These results are fed back to clinical teams within 24 hours of capture, allowing the Trust to act rapidly on patient feedback while patients are still in our care. • 2 Minutes of Your Time: This is a short quick exit survey which allows for a broad coverage across the Trust. Patients answer 6 key questions about the quality of care just before they leave hospital – this has included the Friends and Family question for the last 3 years. All data including all free text comments are fed back to clinical teams within a week. <p>Communicating results with the public: The Trust has developed innovative info graphics to ensure all the experience results are shared with patients, families and the public. Posters are updated each quarter so that the latest results are always on display.</p> <p>Supporting staff to deliver patient-centred care: In designing the programme in 2010 the Trust deliberately aimed for a patient centred approach. What they hadn't appreciated was the degree to which the real time programme would engage and</p>	<p>Looking at whether patients can leave feedback easily has been a component of the new the Care Quality Commission inspections from October 2014 onwards. Complaints will be a key line of enquiry in the Care Quality Commission inspections from October 2014, and this includes looking at a random sample of closed complaints to see how they were investigated, and to look at how the Trust learnt from the complaint and embedded the change in the organisation. The Care Quality Commission will also be looking at the ward environment. Within the inspections, the Care Quality Commission will be able to look at whether the method of investigating the complaint was appropriate for the issue involved i.e. that in serious cases, independent investigation was conducted</p>

		<p>support staff. In the annual NHS staff survey the Trust performs exceptionally well, with 94 per cent feeling their work makes a real difference.</p> <p>Key learning from implementation has included the following:</p> <ul style="list-style-type: none"> • no single method has given the Trust all they need – they continue to rely on a combined approach; • they've seen significant benefits of real time reporting; • executive management team support has been crucial; • ensure patients and families are part of the improvement team – this could be a ward based team or multidisciplinary team across a service; • Patients have been involved in information development, teaching and training, service evaluation and mystery shopping; • focusing on metrics that matter most has made sense; • incremental roll out, change and improvement has given time for the programme to embed properly; • keep expenditure on measurement to a minimum – invest in improving instead; • qualitative feedback appears particularly important in engaging staff; and • transparency of reporting matters. 	
257	<p>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.</p>	<p>Accepted in principle.</p> <p>We accept that the Health and Social Care Information Centre should be made more independent. In April 2013, the Health and Social Care Information Centre was established as an Executive Non Departmental Public Body to further ensure its independence in the undertaking of its key functions.</p> <p><i>The Health and Social Care Act 2012</i>, requires the Health and Social Care Information Centre to establish and operate a system for the collection or analysis of information in connection with the provision of health services and adult social care in England. As such, its work includes the publication of more than 130 statistical publications annually; providing a range of specialist data services; managing informatics projects and programmes and developing and assuring national systems against appropriate contractual, clinical safety and information standards.</p> <p>The Informatics Services Commissioning Group, established in 2013, has been set up to enable the Health and Social Care Information Centre to become the focal point for data collected at the national level so that it increasingly becomes a checkpoint for those seeking new data collections.</p> <p>At this time, we do not accept that this should include the information functions previously held by the NPSA. Following the abolition of the National Patient Safety Agency, its key functions were transferred to NHS England in 2012 including functions relating to the National Reporting and Learning System. The operational management of the National Reporting and Learning System was transferred for two years from 1 April 2012 to Imperial College Healthcare NHS Trust.</p>	<p>Work to re-commission the National Reporting and Learning System is underway in NHS England with ongoing stakeholder and expert engagement being used to inform the design phase. The options development and appraisal will be progressed in Q3 and Q4 of 2014/15 with the revised design confirmed by the end of March 2015, subject to approvals. The procurement of the new system will then progress over the 2015/16 financial year.</p>

		Given the recent transfer of these functions, the Government stated in its initial response to The Inquiry, <u>Patients First and Foremost</u> (Department of Health, 2013), that reallocating these functions at this stage would be unnecessarily disruptive. We will keep this decision under review.	
258	The Information Centre should continue to develop and maintain learning, standards and consensus with regard to information methodologies, with particular reference to comparative performance statistics.	<p>Accepted.</p> <p>The Health and Social Care Information Centre publishes, and keeps under regular review, the methodologies used for the calculation of national indicators and statistics.</p> <p>To support this function the Health and Social Care Information Centre:</p> <ul style="list-style-type: none"> • has introduced an assurance process for indicators on behalf of the Quality Information Committee (a subcommittee of the National Quality Board). This process ensures that indicators are fit for purpose and is available as a service for any organisation to use. The Health and Social Care Information Centre keeps indicators under review to ensure that, where improvements or quality issues are identified, learning is maintained and lessons implemented; • adheres to principle four the <u>Code of Practice for Official Statistics</u> (UK Statistics Authority, January 2009) which states, '<i>Statistical methods should be consistent with scientific principles and internationally recognised best practices, and be fully documented. Quality should be monitored and assured taking account of internationally agreed practices</i>'; and • publishes additional contextual data to help people use or interpret the data it publishes, including, for example, information about palliative care coding in the context of the Summary Hospital-level Mortality Indicator. 	The Health and Social Care Information Centre has been working with Health Education England regarding the implications for the new workforce strategy (Skill and Capabilities). As a result, the National Information Board Framework will make specific proposals about the need for workforce strategies to address informatics skills and capabilities.
259	The Information Centre, in consultation with the Department of Health, the NHS Commissioning Board and the Parliamentary and Health Service Ombudsman, should develop a means of publishing more detailed breakdowns of clinically related complaints	<p>Accepted.</p> <p>The Department of Health will work with the Health and Social Care Information Centre to put complaints data into the existing NHS electronic data collection system, better enabling comparison between hospitals.</p>	<p>The Department of Health, working with the Health and Social Care Information Centre, committed to developing a system that enabled Trusts to publish accurate, detailed quarterly data on the number of complaints received, and to enable comparison across hospitals.</p> <p>The overall aim of the revisions is to provide members of the public and regulatory bodies with frequent, more meaningful data which will identify organisations whose level of complaints, whether high or low, suggests there may be cause for concern.</p> <p>Hospitals will begin revised collections from April 2015, with the first quarterly report envisaged by late summer 2015. It is expected the public can begin to compare Trusts' complaints data by late Autumn 2015.</p> <p>However, the Consultation is complete with our responses published. The Department of Health have now written out to NHS Complaints Managers and advised them of the changes to the NHS Complaints Data Collection and from April 2015 data will be collected and published quarterly.</p>
260	The standards applied to statistical information about serious untoward incidents should be the same as for any other healthcare information and in particular the principles around 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.	<p>Accepted in principle.</p> <p>Where appropriate to do so, information standards should be applied to the reporting of serious incidents and that such information should be made as transparent and accessible as possible. The Government also supports the principle outlined in the UK Statistics Authority's <u>Code of Practice for Official Statistics</u> (January 2009) that statistical producers will publish data that meets the needs of users and are readily available to them alongside a full and frank commentary.</p> <p>Responsibility for the reporting of patient safety incidents was transferred to NHS England in 2012 following the abolition of the National Patient Safety Agency. See</p>	<p>Work to re-commission the National Reporting and Learning System is underway in NHS England with ongoing stakeholder and expert engagement being used to inform the design phase. The options development and appraisal will be progressed in Q3 and Q4 of 2014/15 with the revised design confirmed by the end of March 2015, subject to approvals. The procurement of the new system will then progress over the 2015/16 financial year.</p> <p>The current functions of the Strategic Executive Information System and the National Reporting and Learning System will be incorporated; one single incident reporting system is a key tenet of the proposed changes in order to reduce the risks associated with duplication and to streamline reporting</p>

		<p>recommendation 257 for further details. NHS England publishes patient safety incident data each month from the National Reporting and Learning System, including information on levels and severity of harm to patients.</p> <p>NHS England is exploring the extent to which information on serious incidents can be disclosed in more detail without breaching the <u>Data Protection Act 1998</u>. It should be noted, however, that information reported on serious incidents is provided specifically to ensure the robust management of the response to a specific serious incident. The reported information is, therefore, sensitive and has to be appropriately protected. It is not collected for the purposes of measuring activity or outcomes and is in that sense very different from other types of information collected by the Health and Social Care Information Centre.</p> <p>NHS England is reviewing the National Reporting and Learning System with a range of key stakeholders including the Health and Social Care Information Centre. As part of the review NHS England will consider the reporting of data from the National Reporting and Learning System and the data standards applied to the National Reporting and Learning System to ensure, where appropriate, they are the same as those applied by the Health and Social Care Information Centre to other data streams.</p> <p>NHS England is also reviewing the Strategic Executive Information System, the reporting mechanism for both clinical and information incidents, in order to consider procuring a replacement. As information incidents are also reported through the information governance toolkit held by the Health and Social Care Information Centre, consideration will be given by NHS England and the Health and Social Care Information Centre to streamlining these reporting mechanisms to reduce burden.</p>	<p>processes. Extensive consultation with stakeholders has taken place and the intelligence gathered is now informing the identification and development of a range of possible options to progress the work. The next stage will be to undertake a formal options assessment process, including technical feasibility.</p> <p>We have published monthly data on Never events reported to the Strategic Executive Information System since April 2014. In order to publish further the Strategic Executive Information System data that is publically comprehensible and does not risk identifying individuals, data fields currently collected in the Strategic Executive Information System will need to be revised. We are working through proposed changes to ensure these data field changes are both technically feasible and acceptable to patients and system users with a view to applying any changes made for the start of FY 15/16.</p>
261	<p>The Information Centre should be enabled to undertake more detailed statistical analysis of its own than currently appears to be the case.</p>	<p>Accepted.</p> <p>The Health and Social Care Information Centre collects and publishes national data and statistical information in health and social care as required by <i>The Health and Social Care Act 2012</i>. In doing so, the Health and Social Care Information Centre also has a role in undertaking high level analysis of data, where appropriate, to support the interpretation of information prior to its publication. For example in the preparation of the Summary Hospital- level Mortality Indicator. This is a useful function and the Health and Social Care Information Centre will continue to do this wherever appropriate.</p> <p>The Health and Social Care Information Centre will also ensure that data which can be interpreted locally is available and in a format that would allow individual organisations to undertake that analysis. The Health and Social Care Information Centre does not provide local level interpretative analysis, rather it will continue to ensure that such information is available so that it can be used by local trusts and data intermediaries to add value by presenting the data in ways that are most useful to specific local audiences. This is in line with the Government's Information Strategy, <u>The Power of Information</u> (Department of Health, May 2012).</p>	<p>The Health and Social Care Information Centre is currently reviewing its publications strategy to ensure that its outputs are providing relevant and useful statistics and analyses for customers and the public. As part of this review, it has started to produce more thematic reports, for example regarding health and care services for older people, which was published in June 2014.</p>
262	<p>All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them:</p> <ul style="list-style-type: none"> Effective real-time information on the performance of each of their services 	<p>Accepted.</p> <p>Timely, accurate and robust data should be used by every provider to determine the quality of the services that they provide and identify whether there are any risks to patient safety. Wherever possible, such information should be available to commissioners, regulators and the public to drive improvement and support choice.</p> <p>To support this, for example:</p>	<p>NHS England plans to publish consultant-level outcomes data from all appropriate NHS funded national clinical audits before 2020. Consultant Outcomes Publication began with ten national clinical audits in June 2013 which were also made available through the NHS Choices Website. Consultant data for neurosurgery and upper gastro-intestinal has also now been published. NHS England will improve the way in which data is published and has supported the development of patient-friendly guidance which has been issued to professional societies. This outlines the indicators that must be included in consultant level reporting such as patient involvement in publication and the linking of results for</p>

	<p>against patient safety and minimum quality standards;</p> <ul style="list-style-type: none"> Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> the NHS Leadership Academy in <i>The Healthy NHS Board</i> (NHS Leadership Academy, 2013) set out clear roles for regarding the use of information across the board. It stated that Executive Directors should take ‘... <i>principal responsibility for providing accurate, timely and clear information to the board</i>’. (see recommendation 245); and data on providers’ performance is becoming increasingly available including data at specialty level (see recommendation 264) and the provider’s compliance with quality standards (see recommendation 246 regarding quality accounts). <p>However, rather than determining how local providers should meet their information needs centrally, the Department of Health is committed to connecting existing systems, see <i>Liberating the NHS: An Information Revolution</i> (Department of Health, July 2010) and <i>The Power of Information</i> (Department of Health, May 2012). As such, providers will set specific requirements locally but based on national standards to ensure that information can be shared across the system.</p> <p>Some national standards have already been set, including the use of the NHS number, and further standards, such as interoperability of patient records, will be outlined in NHS England’s Technology Strategy, which is due to be published in early 2014.</p>	<p>the department to an individual’s work at the trusts in which they practice.</p>
263	<p>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.</p>	<p>Accepted.</p> <p>The Government stated in <i>Patients First and Foremost</i> (Department of Health, 2013) that, ‘<i>From 2015, [NHS England] will ensure that data on services at specialty level is increasingly available. To do this they will work with providers, patient groups and specialty level organisations and those bodies such as the Health and Social Care Information Centre and the Care Quality Commission...</i>’</p> <p>It is important for healthcare professionals to provide information of this kind which will act as a catalyst for improvements in audit quality, participation and analysis that will enable fuller transparency. As the recent publication of outcome data for a number of surgical specialties has shown, we are at the start of an age of much greater openness about the quality of care, and all in the NHS, including health professionals, need to play their part in opening up information for patients and the public. The publication of this data has already stimulated specialist societies to take ownership of the setting and monitoring of clinical standards.</p>	<p>Medical Royal Colleges have actively supported the publication of individual consultant outcome data in the relevant specialties. The Consultant Outcomes Publication began with ten national clinical audits in June 2013; the information published is available on the NHS Choices Website and 2014 data will be published on My NHS. So far, over 99 percent of consultants have agreed or not objected to information regarding their practice being published and compliance with plans to report consultant-level data became mandatory, through the NHS standard contract, in 2014/15. Consultant data for neurosurgery and upper gastro-intestinal has also now been published. NHS England is looking into which outcomes data could be most usefully and feasibly collected to extend the programme. In addition, the Academy of Medical Royal Colleges’ 2013 publication “i-care: Information, Communication and Technology in the NHS” reiterated the commitment to transparent collection and provision of information and the involvement of clinicians in the provision and use of clinical data.</p>
264	<p>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.</p>	<p>Accepted.</p> <p><i>The Mandate</i> (Department of Health, November 2013) NHS England states that, ‘<i>The NHS should measure and publish outcome data for all major services by 2015, broken down by local clinical commissioning groups where patient numbers are adequate, as well as by those teams and organisations providing care.</i>’</p> <p>To meet this commitment, the Government stated in <i>Patients First and Foremost</i> (Department of Health, 2013) that, ‘<i>From 2015, [NHS England] will ensure that data on services at specialty level is increasingly available. To do this they will work with providers, patient groups and specialty level organisations</i></p>	<p>NHS England plans to publish consultant-level outcomes data from all appropriate NHS funded national clinical audits before 2020. Consultant Outcomes Publication began with ten national clinical audits in June 2013 which were also made available through the NHS Choices Website. Consultant data for neurosurgery and upper gastro-intestinal has also now been published. NHS England will improve the way in which data is published and has supported the development of patient-friendly guidance which has been issued to professional societies. This outlines the indicators that must be included in consultant level reporting such as patient involvement in publication and the linking of results for the department to an individual’s work at the trusts they practice in.</p>

		<p><i>and those bodies such as the Health and Social Care Information Centre and the Care Quality Commission...'</i></p> <p>In June 2013, NHS England published the first two specialities level data, cardiac surgery and vascular, and announced the publication schedule for a further eight specialities. All specialities have now been published. NHS England will widen this programme to include other specialities over time and the data published will, initially, be refreshed annually. The data can be accessed via NHS Choices.</p> <p>Recommendations 265, 266 and 267 relate to this programme of work and are responded to accordingly.</p>	
265	<p>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.</p>	<p>Accepted.</p> <p>On behalf of NHS England, the Healthcare Quality Improvement Partnership has worked with specialist associations to develop the data referred to in recommendation 264 from selected national clinical and medical audits for consultants practising in these areas. The data is currently made available through NHS Choices website so that it can be used to meet a wide range of purposes. Providers will be expected to link to this data from their own websites from the summer of 2013.</p> <p>NHS England will continue to work on how to improve the experience of this data through NHS Choices and promote patient knowledge and choice.</p>	<p>Consultant Outcomes Publication began with ten national clinical audits in June 2013 which were also made available through the NHS Choices Website. Consultant data for neurosurgery and upper gastro-intestinal has also now been published. NHS England is looking into which outcomes data could be most usefully and feasibly collected to extend the programme.</p> <p>NHS England will improve the way in which data is published and has supported the development of patient-friendly guidance which has been issued to professional societies. This outlines the indicators that must be included in consultant level reporting, such as patient involvement in publication and the linking of results for the department to an individual's work at the trusts in which they practice.</p>
266	<p>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.</p>	<p>Accepted.</p> <p>There is a clear role for the users of services in the development of appropriate information and statistics. The UK Statistics Authority's Code of Practice for Official Statistics (January 2009) outlines a protocol on user engagement the basis of which, including the need to understand the requirements and views of the users of information, are applicable to the development of all information.</p> <p>The Health and Social Care Information Centre works with a range of relevant stakeholders and experts in the design and presentation of its statistics. It recognises that it needs to do more in this regard, and will be reviewing its publications strategy accordingly.</p> <p>While the initial development of specialty level statistics as outlined in recommendation 264 had limited input from patient groups, NHS England will consider carefully the role of service users in taking this programme of work forward.</p>	<p>See update to recommendation 264. In addition, NHS England is launching a programme of composite indicator development which will provide an 'at a glance' view of how well hospital services are performing. This will roll out over 10 clinical areas throughout 2014-2016. The development of the markers will be commissioned from those organisations that have the skills, experience and data to do the work effectively - most likely this will be drawn from existing clinical audits and intelligence networks. In developing the new markers, a central requirement is that proper regard is given to the priorities of patients. Additionally the individual indicators that make up each composite will be made available so that patients, clinicians and managers can better understand the variations that exist within and between services.</p>
267	<p>All such statistics should be made available online and accessible through provider websites, as well as other gateways such as the Care Quality Commission.</p>	<p>Accepted.</p> <p>The data referred to in recommendation 264 is made available through NHS Choices website so that it can be used to meet a wide range of purposes. Providers are expected to link to this data from their own websites from the summer of 2013.</p> <p>NHS England will continue to work on how to improve the experience of this data through NHS Choices and promote patient knowledge and choice.</p>	<p>Specialist associations publish the data referred to in recommendation 264 on their own websites. In 2014 NHS Choices published the outcomes. Users are able to look up this data at provider level, in addition to searching by name or speciality.</p>
268	<p>Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry.</p>	<p>Accepted.</p> <p>In order to ensure that good quality data is collected locally and made available to central repositories such as the Health and Social Care Information Centre, resources need to be available to providers of services such that collections of</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>

		<p>data can be undertaken.</p> <p>A wide range of data is collected locally to be used by providers, commissioners, regulators, patients and the public to determine performance and compliance with basic requirements of quality and safety. For example, recommendation 246 discusses data needed for comparable quality accounts and 98 recommendation outlines the reporting of serious patient safety incidents via the National Reporting and Learning System.</p> <p>Where collections are mandated, resources are allocated to the provider as part of their overall budgets, by the relevant commissioning body via the NHS Standard Contract, to ensure their collection. It is the responsibility of all providers to ensure that resources are allocated internally to ensure that data are collected and made available as appropriate.</p> <p>In addition to this, we also support initiatives that improve the use of appropriate technology and remove unnecessary burden from the collectors of data. The NHS Confederation's review, <i>Challenging Bureaucracy</i> (2013), the work and tools developed by the Health and Social Care Information Centre in busting bureaucracy, and NHS England's Clinical Bureaucracy Index are all intended to support a reduction of burden, nationally and locally, to allow staff to focus on the delivery of good quality care.</p>	
269	<p>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.</p>	<p>Accepted.</p> <p>It is the role of local providers to ensure that the accuracy of the data it generates and submits into the system. As such, existing requirements for local audit of clinical records and the external audit of clinical coding data quality are important and will continue.</p> <p>However, the Health and Social Care Information Centre also has an important role to play regarding the assurance of the quality of the data it receives. It will assess the extent to which the information it collects meets the information standards and publish its findings routinely, when it publishes data or statistics.</p> <p>The Health and Social Care Information Centre published the first national data quality report, <i>The Quality of Nationally Submitted Health and Social Care Data in England – 2012</i> (July 2012) which highlighted a number of consistent areas which lead to poor quality data including:</p> <ul style="list-style-type: none"> • lack of standards and guidance; • poor training and awareness of the impact of poor quality data; • local system updates and changes; • reorganisation and reconfiguration of services; and • knowledge and use of the data and its quality. <p>The Health and Social Care Information Centre has published its second annual report, <i>The Quality of Nationally Submitted Health and Social Care</i> (September 2013) built on these areas.</p> <p>The Health and Social Care Information Centre is also developing a <i>National Data Quality Assurance Framework</i> that will outline data quality standards and compliance with these standards. The Health and Social Care Information Centre will publish these assessments in order to incentivise improvement in the quality of data. In 2012–13 The Health and Social Care Information Centre will develop the National Data Quality Assurance Framework by, for example:</p>	<p>The next update to the Health and Social Care Information Centre's National Data Quality Assurance Framework is expected to go live shortly. It uses one web page to give a single point of access to all the Health and Social Care Information Centre data quality information. It will include links to data quality metadata for data assets recorded in the Health and Social Care Information Centre's information register. It will also give access to the data quality results output from the Health and Social Care Information Centre's data quality assessment processes for each data provider expected to submit mandatory data collections.</p> <p>The Health and Social Care Information Centre published its third national report on data quality on 30 October 2014.</p>

		<ul style="list-style-type: none"> defining, developing and expanding measures for assessing data quality to provide more comprehensive assessments in future years; reviewing and developing collection and reporting systems and providing consistent and visible outputs on the quality of data; and publishing data quality assessments on a more frequent basis in the year. <p>The Health and Social Care Information Centre also produce a range of data quality reports and dashboards to help local providers improve the quality of the data they return. These include, for example, in relation to the Secondary Uses Service, Hospital Episode Statistics and the Mental Health Minimum Data Set.</p>	
270	<p>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.</p>	<p>Accepted.</p> <p>The UK Statistics Authority is undertaking an independent review of patient outcome statistics recognised as official statistics. The review, among other things, is considering how to make such statistics more readily useable by the public. In undertaking the review the UK Statistics Authority has had discussions with the Health and Social Care Information Centre, NHS England, Department of Health, Care Quality Commission and the Office for National Statistics. The report will be published later in 2013 and we will study its findings closely with a view to help improve presentation of statistics to patients and the public.</p>	<p>The UK Statistics Authority published its review <i>Official Statistics on Patient Outcomes in England</i> in February 2014. This was accompanied by a letter to the Secretary of State for Health, which invited him to put forward seven sets of patient outcome statistics for independent the UK Statistics Authority assessment. The letter also proposed further recommendations for the statistics producers - namely the Health and Social Care Information Centre, NHS England, and the Care Quality Commission - to improve the usability of their statistics. The Secretary of State for Health formally requested the proposed assessments, and noted that the statistics producer bodies would consider the other recommendations. Assessments for five of the seven sets of statistics have already begun, including the Summary Hospital-level Mortality Indicator, with the other two scheduled to begin in 2015. This is intended to provide independent assurance that these important statistics comply with best practice. The statistics producers are working together to understand the views of service users and the public on how the publication of these statistics can be made more accessible, clear and at a level of detail that supports their use.</p>
271	<p>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.</p>	<p>Accepted.</p> <p>The <u>Summary Hospital-level Mortality Indicator</u> which reports mortality data at trust level across the NHS in England, has been produced and published by the Health and Social Care Information Centre as an experimental Official Statistic since October 2011.</p> <p>The UK Statistics Authority's independent review of patient outcome statistics referred to in relation to recommendation 270 includes in scope a review of the Summary Hospital-level Mortality Indicator, its accessibility to patients and the public, and its status as Official Statistics. We expect the review to recommend that the Summary Hospital-level Mortality Indicator is assessed by UK Statistics Authority against the <i>Code of Practice for Official Statistics</i> (January 2009) with a view to securing designation as National Statistics.</p> <p>In July 2013, Professor Sir Bruce Keogh published his <i>Review into the quality of care and treatment provided by 14 hospital trusts in England</i>. In his report Sir Bruce announced that he had asked Professor Nick Black and Professor Lord Ara Darzi to undertake a study into the relationship between excess mortality rates and actual avoidable deaths. This study is expected to pave the way for the introduction of a new national indicator on avoidable deaths in hospital measured through case notes reviews</p>	<p>The UK Statistics Authority's review <i>Official Statistics on Patient Outcomes in England</i> recommended that Summary Hospital-level Mortality Indicator should be assessed against the Statistics Code. That assessment has begun. Professor Nick Black's study has also commenced with preliminary results from the study expected in December 2014. The study is due to be completed in March 2015, after which findings will be published. Robust and accessible reporting of avoidable hospital deaths is not a simple matter, but the intention is to develop presentations and measures which can be understood and used by patients, and acted upon by clinicians and used by patients, and acted upon by clinicians and regulators, in a continual drive to reduce avoidable deaths.</p>
272	<p>There is a demonstrable need for an accreditation system to be available for healthcare-relevant statistical</p>	<p>Accepted.</p> <p>The <i>Health and Social Care Act 2012</i> established powers for the Health and Social</p>	<p>The Health and Social Care Information Centre hosts the Indicator Assurance Service which quality assures the construction of health indicators. The Assurance service is used to quality assure all new indicators put forward for</p>

	<p>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.</p>	<p>Care Information Centre to establish an accreditation scheme for information service providers. The Act allows the Health and Social Care Information Centre to establish a procedure, and set of criteria, for accrediting any information service providers.</p> <p>The Health and Social Care Information Centre set out its objectives for 2013–14 in its publication <i>Informing Better Care</i> (2013) including the delivery of all of its statutory responsibilities as set out in the <i>Health and Social Care Act 2012</i>. The ambitious program includes the delivery of a safe transition from the existing information standards products and services in to the new operating model and the fulfillment of its data quality assurance roles. Given the scope of the program the Health and Social Care Information Centre has committed to deliver, they will not take forward an accreditation system this financial year but will consider how such a system can be taken forward in 2014–15.</p>	<p>inclusion in both the NHS Outcomes Framework and Clinical Commissioning Group Outcomes Indicator Set. The Health and Social Care Information Centre hosts the Indicator Assurance Service which quality assures the construction of health indicators. The Assurance service is used to quality assure all new indicators put forward for inclusion in both the NHS Outcomes Framework and Clinical Commissioning Group Outcomes Indicator Set. The Service has also assured other indicators, not included in established Frameworks, such as the Summary Hospital-level Mortality Indicator, Patient Reported Outcome Measures and Accident and Emergency care quality indicators. Indicators are assured via a collaborative process that draws upon the expertise of colleagues from a broad range of health and social care organisations. To date there have been 231 indicators put forward for appraisal by the Indicator Assurance Service, of which 106 have been assured as being suitable for inclusion in the Library of Quality Assured Indicators. A further 68 indicators are in the process of being appraised under the assurance process. Once approved, the indicators are included in the national Library of Quality Assured Indicators.</p> <p>The Health and Social Care Information Centre is working with its national partners in the National Information Board which has responsibilities relating to health and care information standards and technologies. This collaborative work is ongoing to develop a new informatics strategy, and will use that to set out its proposals for ensuring more systematic use of the indicator assurance function. The service is already available to commercial intermediaries and public sector organisations, but is not yet mandatory. The Health and Social Care Information Centre will therefore need to explore the use of levers and incentives that could be applied so that the service can be used without impeding the development of the commercial analytics market.</p>
273	<p>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.</p>	<p>Accepted in principle.</p> <p>All relevant information should be shared with coroners to ensure that they are able to perform their roles fully. The <i>Coroners and Justice Act 2009</i> states that, <i>'It is an offence for a person to do anything that is intended to have the effect of (a) distorting or otherwise altering any evidence, document or other things that is given, produced or provided for the purpose of an investigation ... (b) preventing any evidence, document or other thing from being given produced or provided for the purposes of such an investigation or to do anything that the person knows or believes is likely to have that effect.'</i></p> <p>The Government does not agree, however, that this should be required in terms of the registration of providers by the Care Quality Commission the function of which is to ensure that providers meet a much wider set of basic requirements to ensure patients' effective and safe treatment and care.</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>
274	<p>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.</p>	<p>Accepted.</p> <p>The <i>Coroners and Justice Act 2009</i> states that, <i>'It is an offence for a person to do anything that is intended to have the effect of (a) distorting or otherwise altering any evidence, document or other things that is given, produced or provided for the purpose of an investigation ... (b) preventing any evidence, document or other thing from being given produced or provided for the purposes of such an investigation or to do anything that the person knows or believes is likely to have that effect.'</i></p> <p>Intentionally suppressing, concealing, altering or destroying a relevant document, except under specific circumstances, is an offence that may result in a fine and/or imprisonment.</p>	<p>No further update is required. Please see response to the recommendation in Hard Truths</p>

275	<p>It is of considerable importance that independent medical examiners are independent of the organisation whose patients' deaths are being scrutinised.</p>	<p>Accepted in principle.</p> <p>The Government agrees that medical examiners must be independent of the deceased and their medical practitioner. This is because medical examiners need carry out independent scrutiny of the medical circumstances and cause of apparently natural deaths, to ensure that the right deaths are notified or referred to a coroner.</p> <p>However, we also need to ensure that there are sufficient numbers of medical examiners to carry out this work (recommendation 276), particularly in rural areas, and, therefore, appointees are likely to have some sort of professional relationship with local care providers.</p> <p>As such, the draft death certification regulations for medical examiners in England does not require that medical examiners are independent of the organisation whose patients' deaths are being scrutinised. However in order to support a greater level of independence in line with the spirit of this recommendation, the Government will review how it can include further safeguards to ensure that independence is protected.</p> <p>Where a medical examiner has any concern that their independence has, or will be, compromised, they are able to raise those concerns directly with the appropriate local authority and/or the National Medical Examiner as needed. The Government will consider the role of the National Medical Examiner further, and the need for best practice guidance, to ensure that medical examiners are not put under any pressure to operate where there independence is compromised.</p>	<p>A number of the recommendations in Sir Robert's Mid Staffordshire Inquiry report refer to our planned reform of the death certification system and the introduction of the role of medical examiner in England and Wales. A new system of medical examiners has been trialled successfully in a number of areas across the country. The work of the two flagship sites in Gloucestershire and Sheffield has been continued and extended to operate a medical examiner service on a city and countywide basis at a scale that will be required for implementation by local authorities when legislation is introduced. We will publish shortly a report from the interim National Medical Examiner setting out the lessons learned from the pilot sites.</p> <p>The government remains totally committed to the principle of these reforms. Further progress will be informed by a reconsideration of the detail of the new system in the light of other positive developments on patient safety since 2010 and by a subsequent public consultation exercise.</p>
276	<p>Sufficient numbers of independent medical examiners need to be appointed and resourced to ensure that they can give proper attention to the workload.</p>	<p>The <i>Coroners and Justice Act 2009</i> requires the appointment of enough medical examiners, and the availability of sufficient funds and resources, to ensure the functions of medical examiners are discharged within the appointing area.</p> <p>It is the responsibility of local authorities, who will appoint medical examiners, to ensure that this is the case. However, to support local authorities in this task, the Department of Health will provide each local authority with estimated numbers of medical examiners that may be required locally based on expected levels of death and workload and match resourcing for medical examiners to that estimation.</p>	<p>A number of the recommendations in Sir Robert's Mid Staffordshire Inquiry report refer to our planned reform of the death certification system and the introduction of the role of medical examiner in England and Wales. A new system of medical examiners has been trialled successfully in a number of areas across the country. The work of the two flagship sites in Gloucestershire and Sheffield has been continued and extended to operate a medical examiner service on a city and countywide basis at a scale that will be required for implementation by local authorities when legislation is introduced. We will publish shortly a report from the interim National Medical Examiner setting out the lessons learned from the pilot sites.</p> <p>The government remains totally committed to the principle of these reforms. Further progress will be informed by a reconsideration of the detail of the new system in the light of other positive developments on patient safety since 2010 and by a subsequent public consultation exercise.</p>
277	<p>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.</p>	<p>Accepted.</p> <p>We intend to publish draft death certification regulations that states that the Chief Medical Officer of the Department of Health must issue guidance on how death certification forms are completed. This will include a standard methodology for completing medical certificate of cause of death and replace previous guidance including that supplied with the book of medical certificates of cause of death to doctors.</p> <p>In addition, medical examiners will support doctors completing medical certificates of cause of death to ensure that they are consistent and of sufficient quality and may recommend further training for doctors where that is deemed necessary.</p>	<p>A number of the recommendations in Sir Robert's Mid Staffordshire Inquiry report refer to our planned reform of the death certification system and the introduction of the role of medical examiner in England and Wales. A new system of medical examiners has been trialled successfully in a number of areas across the country. The work of the two flagship sites in Gloucestershire and Sheffield has been continued and extended to operate a medical examiner service on a city and countywide basis at a scale that will be required for implementation by local authorities when legislation is introduced. We will publish shortly a report from the interim National Medical Examiner setting out the lessons learned from the pilot sites.</p> <p>The government remains totally committed to the principle of these reforms. Further progress will be informed by a reconsideration of the detail of the new system in the light of other positive developments on patient safety since 2010 and by a subsequent public consultation exercise.</p>

278	It should be a routine part of an independent medical examiner'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.	<p>Accepted.</p> <p>The Government intends to publish draft death certification regulations for medical examiners in England that will require that medical examiners obtain and consider information available about patient safety to inform their professional judgement as to the cause of death in a particular case.</p> <p>The Royal College of Pathologists and e-Learning for Healthcare have produced an online learning module to help those involved in the certification of death. This will be updated as soon as possible to reflect these recommendations.</p>	<p>A number of the recommendations in Sir Robert's Mid Staffordshire Inquiry report refer to our planned reform of the death certification system and the introduction of the role of medical examiner in England and Wales. A new system of medical examiners has been trialled successfully in a number of areas across the country. The work of the two flagship sites in Gloucestershire and Sheffield has been continued and extended to operate a medical examiner service on a city and countywide basis at a scale that will be required for implementation by local authorities when legislation is introduced. We will publish shortly a report from the interim National Medical Examiner setting out the lessons learned from the pilot sites.</p> <p>The government remains totally committed to the principle of these reforms. Further progress will be informed by a reconsideration of the detail of the new system in the light of other positive developments on patient safety since 2010 and by a subsequent public consultation exercise.</p> <p>The medical examiner e-learning module will be refreshed following any future consultation to ensure it reflects the relevant Francis recommendations.</p>
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.	<p>Accepted.</p> <p>Existing guidance that is provided with medical certificates of cause of death states that death certification should be completed by a consultant or senior clinician, although this could be delegated to a junior doctor who was in attendance but only where they are closely supervised. This advice will be retained in the new guidance issued by the Chief Medical Officer to accompany the new set of medical certificates of cause of death.</p> <p>The Department of Health intends to publish draft death certification regulations that states that an attending practitioner is a registered medical practitioner who:</p> <ul style="list-style-type: none"> • attended the deceased in the last 28 days for the condition or disease that caused their death, or • is a partner or employee of the same general practice as the attending practitioner and has attended the deceased within the last 12 months for the disease or condition that caused their death. <p>To support those certifying the cause of death:</p> <ul style="list-style-type: none"> • the Chief Medical Officer will issue guidance on how death certification forms are completed in 2014 that will replace existing guidance, and medical examiners will support doctors completing medical certificates of cause of death to ensure that they are consistent and of sufficient quality and may recommend further training where that is deemed necessary. 	<p>A number of the recommendations in Sir Robert's Mid Staffordshire Inquiry report refer to our planned reform of the death certification system and the introduction of the role of medical examiner in England and Wales. A new system of medical examiners has been trialled successfully in a number of areas across the country. The work of the two flagship sites in Gloucestershire and Sheffield has been continued and extended to operate a medical examiner service on a city and countywide basis at a scale that will be required for implementation by local authorities when legislation is introduced. We will publish shortly a report from the interim National Medical Examiner setting out the lessons learned from the pilot sites.</p> <p>The government remains totally committed to the principle of these reforms. Further progress will be informed by a reconsideration of the detail of the new system in the light of other positive developments on patient safety since 2010 and by a subsequent public consultation exercise.</p>
280	Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.	<p>Accepted.</p> <p>The Department of Health intends to publish draft death certification regulations that requires medical examiners to make arrangements to speak to anyone they consider necessary to discuss the circumstances and causes of death and to provide them with the opportunity to mention any matter that might cause a senior coroner to think that the death should be investigated. This includes the family of the deceased and/or the provider of care services.</p> <p>In addition, the certifying doctor can provide any information necessary in establishing the cause of death or to protect individuals health and safety along with his/her certificate for scrutiny.</p>	<p>A number of the recommendations in Sir Robert's Mid Staffordshire Inquiry report refer to our planned reform of the death certification system and the introduction of the role of medical examiner in England and Wales. A new system of medical examiners has been trialled successfully in a number of areas across the country. The work of the two flagship sites in Gloucestershire and Sheffield has been continued and extended to operate a medical examiner service on a city and countywide basis at a scale that will be required for implementation by local authorities when legislation is introduced. We will publish shortly a report from the interim National Medical Examiner setting out the lessons learned from the pilot sites.</p> <p>The government remains totally committed to the principle of these reforms.</p>

			Further progress will be informed by a reconsideration of the detail of the new system in the light of other positive developments on patient safety since 2010 and by a subsequent public consultation exercise.
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.	<p>Accepted.</p> <p>The Royal College of Pathologists and e-Learning for Healthcare have produced an online learning module to help those involved in the certification of death. The training is open to all NHS staff along with all prospective medical examiners.</p> <p>This training consists of 91 sessions within 11 modules that fully trained Medical Examiners will be expected to complete. This training includes a module on interacting with the bereaved and covers topics on the bereavement office; the psychology of bereavement and loss and the medical examiner's role; and supporting the bereaved.</p> <p>Prior to application, all candidates are required to complete a core component of the 91 sessions and present the local appointing panel with a certification of its completion as part of the application process.</p> <p>Where an application is successful, the medical examiner will receive face-to-face training organised by the Royal College of Pathologists and must complete the remaining e-Learning within a year.</p> <p>The e-Learning is currently being reviewed and Royal College of Pathologists and e-Learning for Healthcare will consider recommendations 277, 278, 280 in taking that forward.</p>	<p>A number of the recommendations in Sir Robert's Mid Staffordshire Inquiry report refer to our planned reform of the death certification system and the introduction of the role of medical examiner in England and Wales. A new system of medical examiners has been trialled successfully in a number of areas across the country. The work of the two flagship sites in Gloucestershire and Sheffield has been continued and extended to operate a medical examiner service on a city and countywide basis at a scale that will be required for implementation by local authorities when legislation is introduced. We will publish shortly a report from the interim National Medical Examiner setting out the lessons learned from the pilot sites.</p> <p>The government remains totally committed to the principle of these reforms. Further progress will be informed by a reconsideration of the detail of the new system in the light of other positive developments on patient safety since 2010 and by a subsequent public consultation exercise.</p> <p>The medical examiner e-learning module will be refreshed following any future consultation to ensure it reflects the relevant Francis recommendations.</p>
282	Coroners should send copies of relevant Rule 43 reports to the Care Quality Commission.	<p>Accepted.</p> <p>The <i>Coroners and Justice Act 2009</i> states that where a senior coroner has conducted an investigation and anything has been revealed that indicates a risk of other deaths then the coroner, '<i>...must report the matter to a person who the coroner believes has the power to take such action</i>'. (Schedule 5, Paragraph 7).</p> <p>As stated in recommendation 45, the Care Quality Commission already receives prevention of future death reports (previously referred to as rule 43 reports). In September 2013 the Chief Coroner's Office sent out additional guidance, <i>Reports to prevent Future Deaths</i>, to coroners to further support the sharing of this information. This guidance stated that, '<i>Coroners should routinely send relevant reports to other organisations, such as ... the Care Quality Commission</i>'</p>	<p>The Care Quality Commission is undertaking an analysis of the information available from coroners' investigations and inquests, along with other information it already receives relating to expected and unexpected deaths. It will consider the findings of that analysis, including how it could target requests for information from coroners and any burden that collecting this data might impose, working with the Coroners' Society of England and Wales, the Office of the Chief Coroner, the Ministry of Justice and the Department of Health.</p> <p>In addition, the Care Quality Commission is also working with the Coroners' Society of England and Wales and the Office of the Chief Coroner in establishing a Memorandum of Understanding with the aim of achieving better working relationships and the sharing of information. The Care Quality Commission continues to receive prevention of future death reports, and received 127 notices between August 2013 and August 2014.</p> <p>The Care Quality Commission is the process of developing a single protocol for handling information from Coroners, which includes storing and passing on the information. The protocol also outlines how the information received from Coroners will be fed back into the Care Quality Commission, including incorporation into planning inspections, 'lessons learned', reporting back to the Executive Team and external reporting back to Coroner's offices on any trends or themes that might become apparent in the data.</p>
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.	<p>Accepted.</p> <p>The Judicial College has taken responsibility for training all coroners and coroner's officers under the remit of the Chief Coroner's Office from July 2013. The College has already supplied training to coroners on the <i>Coroners and Justice Act 2009</i> and will develop training for all coroners' officers on their roles. This will cover how to</p>	<p>The Judicial College has a programme of mandatory coroner training in place for 2013-14, including 12 courses covering the new legislation and two induction courses. A programme of annual continuation training for coroners began in April 2014 and is ongoing. The Judicial College are also developing plans for coroner officer training. A training needs analysis questionnaire was issued to coroners officers in April 2014 and the Judicial College are using the results to</p>

		involve bereaved families when gathering information in connection with the coroner's investigation. We anticipate that this training will be available from 2014.	design coroner officer training.
284	The Lord Chancellor should issue guidance as to the criteria to be adopted in the appointment of assistant deputy coroners.	<p>Accepted.</p> <p>This has been taken forward by the Chief Coroner. Local Authorities are responsible for all coroner appointments with the consent of the Lord Chancellor and the Chief Coroner.</p> <p>The Ministry of Justice and the Chief Coroner have developed guidance, <i>The Appointment of Coroners (July 2013)</i>, for Local Authorities on coronial appointments, including the qualifications and process for all coroner appointments. The guidance specifies details for the appointment of assistant coroners based on the main process for senior coroners with an understanding that there may be a need for appropriate flexibility due to the volume of posts and the need to involve the senior coroner in the process.</p> <p>This guidance is intended to ensure that the process for appointments is as robust, consistent and transparent as possible.</p>	No further update is required. Please see response to the recommendation in Hard Truths
285	The Chief Coroner should issue guidance on how to avoid the appearance of bias when assistant deputy coroners are associated with a party in a case.	<p>Accepted.</p> <p>The Chief Coroner will look carefully at the issue of bias, and the appearance of bias, and consider whether guidance or training by the Judicial College could be used to address these concerns.</p>	The current round of coroner continuation training and Chief Coroner guidance will cover the issue of bias.
286	<p>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:</p> <ul style="list-style-type: none"> • 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 	<p>Accepted.</p> <p>It is good practice for all major changes of policy and of system structure to be carefully considered and taken forward on the basis of a clearly defined purpose and with a clear and detailed implementation plan that takes account of the major risks to the safety or welfare of patients, and to the effective operation of the system. When the policy or change of system structure is completed, or has advanced to a predetermined degree, it should undergo a comprehensive evaluation.</p>	No further update is required. Please see response to the recommendation in Hard Truths

	<p>change?</p> <ul style="list-style-type: none"> • 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	<p>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.</p>	<p>Accepted.</p> <p>The Care Quality Commission has consulted on fundamental standards of care, which the Department of Health will reflect in regulations. While the focus is on hospital services in the first instance, a new Chief Inspector of General Practice and Chief Inspector of Adult Social Care took up post in the Care Quality Commission in October 2013 and will extend and develop guidance on the regulations for providers into their respective sectors.</p> <p>Attention will be given to how the fundamental standards of care are presented to providers and especially to the public, in particular so as to clarify the relationship to rights under the NHS Constitution and consumer rights, and to present their relationship to other standards and to the Care Quality Commission's own broader ratings of quality. The Care Quality Commission's three Chief Inspectors will engage with the public, providers and professionals to develop guidance that makes clear for all sectors what compliance with the regulations involves and how it joins up with other rights and entitlements, other standards, and the Care Quality Commission's broader assessment of the quality of services.</p> <p>In June 2013, the Care Quality Commission issued <i>A new start – Consultation on changes to the way CQC regulates, inspects and monitors care</i>. This document started the public discussion on what the fundamental standards of care should be. The consultation engaged 5,154 individuals and 4,500 organisations, plus 41 consultation events. The Department will consult shortly on draft regulations in October 2013 which will specify the fundamental standards as outcomes that must be avoided. Subject to Parliament, these will come into force during 2014.</p> <p>The Department has revised the <i>NHS Constitution</i> to give greater prominence to NHS values, and it will consider further revision to the NHS Constitution to reflect this response to The Inquiry.</p> <p>NHS England has agreed with the National Institute for Health and Care Excellence that the concept of enhanced standards is represented by the existing quality standards, which are developed by the National Institute for Health and Care Excellence and endorsed by NHS England. The Care Quality Commission will use (enhanced) quality standards to inform their quality ratings of providers. The National Institute for Health and Care Excellence will also include 'developmental' standards within quality standards, where there are emergent evidence-based technologies with the potential to drive widespread improvements.</p>	<p>Between January and April 2014, the Department of Health consulted on new fundamental standards regulations which will come into force for all providers of health and social care in April 2015. The response to the <u>consultation</u> was published in July 2014.</p> <p>The <u>draft regulations</u> are also laid in Parliament.</p> <p>Between 09 April and 04 June 2014, the Care Quality Commission consulted on how it planned to change the way it regulates, inspects and rate care services and published consultation handbooks for different types of provider. The handbooks cover <u>hospitals</u>, <u>specialist mental health services</u>, <u>community health services</u>, <u>adult social care</u>, and <u>GP and out of hours services</u>.</p> <p>The National Institute for Health and Care Excellence has adapted its development processes to introduce developmental statements in its quality standards where appropriate. The National Institute for Health and Care Excellence consulted on its updated quality standards process guide that makes detailed proposals for how developmental statements will be identified and produced. The <u>consultation</u> document is also available online.</p> <p>The Government has passed legislation that will put in place new fundamental standards as requirements for registration with the Care Quality Commission. These fundamental standards set the level below which care must not fall. Where providers fail to meet these standards the Care Quality Commission will be able to use its enforcement powers to protect patients and service users from the risks of poor care – including prosecuting providers where a failure to meet a fundamental standard results in avoidable harm to a patient or service user, or a significant risk of such harm.</p> <p>The fundamental standards will come into force for all providers registered with the Care Quality Commission in April 2015. Two new regulations introducing a duty of candour for NHS bodies and a fit and proper person requirement for directors of NHS bodies came into force in November 2014</p> <p>In July 2014, the Care Quality Commission consulted providers, health care professionals and other key stakeholders on proposed guidance on meeting the new regulations. The Care Quality Commission published final guidance ahead of the fundamental standards coming into force in November 2014 on duty of candour and the fit and proper person requirement for NHS bodies.</p> <p>The Care Quality Commission has also recently published a series of provider handbooks that will sit alongside the guidance on the regulations and describe the end to end inspection process, including how the Care Quality Commission will judge what good quality care looks like and how the Care Quality Commission will rate providers. The handbooks cover <u>hospitals</u>, <u>specialist mental health services</u>, <u>community health services</u></p>

			The Care Quality Commission is also producing targeted information for the public on the new 11 fundamental standards and standards of care people have a right to expect.
288	The Department of Health should ensure that there is senior clinical involvement in all policy decisions which may impact on patient safety and well-being.	<p>Accepted.</p> <p>The Department of Health has put in place arrangements to ensure that it has access to clinical advice on the full range of issues it deals with. The mechanisms employed include direct employment of clinical advisers where appropriate, and access to advice from senior clinicians elsewhere in the system. In addition to these formal mechanisms, the Department's programme of connecting to front-line practitioners and organisations will, we believe, provide the basis for long-term informal networks of advice that officials will be able to draw upon when developing policy.</p>	No further update is required. Please see response to the recommendation in Hard Truths
289	Department of Health officials need to connect more to the NHS by visits, and most importantly by personal contact with those who have suffered poor experiences. The Department of Health could also be assisted in its work by involving patient/service user representatives through some form of consultative forum within the Department.	<p>Accepted.</p> <p>A major programme has been established within the Department of Health to ensure that staff throughout the organisation are given the opportunity to experience the realities of life in front-line organisations. The programme has begun, with the most senior civil servants in the Department spending time with a wide range of health and care organisations. The early evidence is that the programme is having a profound and positive effect on those participating in it, and has provided them with invaluable insights into the realities of care that they are using to inform their work in the Department.</p>	<p>Within the first year of the Connecting programme, the Department of Health has arranged over 2,000 connecting days, with Senior Civil Service and policy makers spending time shadowing staff and talking to patients and service users in acute care, GP surgeries, social care, community services and the voluntary sector. Over 500 Department of Health staff have taken part in the programme so far, with a number of connecting partners also being invited back into the Department, to learn about policy making and the parliamentary process.</p> <p>A recent survey of Department of Health staff who had connected revealed over 85% had a better understanding of the health and care system as a result, and almost two thirds had increased their number of useful contacts outside the Department. And 86% of the health and care partners the Department of Health surveyed believe the Connecting programme is a good opportunity for civil servants to see what it's really like for patients and those using services.</p> <p>After only one year, Connecting is beginning to help shape the way business is done in the Department. A quarter of those asked reported that connecting had already changed the way they worked, with people using their new contacts as informal sounding boards, developing better dialogue with partners, and having a greater focus on patient experience and, sometimes, unintended consequences of policies.</p>
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.	<p>Accepted.</p> <p>In respect of deficiencies wherever they come in the health and care system, the Department of Health needs to be explicitly and clearly on the side of patients and the public. We have put in place a number of measures to increase transparency in the NHS including the duty of candour on organisations, and the appointment of Chief Inspectors of Hospitals, Primary Care and Adult Social Care. These measures will help to identify poor practice, increase public accountability and, while for some the exposure of failings in care will be difficult, over the long-term we expect these measures will increase public trust in health and care organisations.</p>	The Department and the national organisations for the NHS have continued to put in place a number of measures to ensure that there is widespread transparency for patients and the public. The 'my NHS' website is providing more detailed, comparative information for patients and the public than ever before. The duty of candour will form part of the Fundamental Standards, and comes into force for NHS bodies in November 2014 and apply to all providers of health and care services registered by the Care Quality Commission from April 2015.

