



Department
of Health

Culture change in the NHS

Applying the lessons of the Francis Inquiries



Culture change in the NHS

Applying the lessons of the Francis Inquiries

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

February 2015



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at www.gov.uk/government/publications

Any enquiries regarding this publication should be sent to us at:

Department of Health, 79 Whitehall, London SW1A 2NS

Print ISBN 9781474112116

Web ISBN 9781474112123

ID 2902930 02/15

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office

Contents

Foreword	3
Executive summary	5
Chapter 1 – Preventing problems	19
Chapter 2 – Detecting problems quickly	37
Chapter 3 – Taking action promptly and ensuring robust accountability	41
Chapter 4 – Ensuring staff are trained and motivated	47
Chapter 5 – Conclusion	53
Annex – Taking action promptly: Trusts in Special Measures	55

Foreword

By the Secretary of State for Health

Almost the first thing I did when I was appointed as Health Secretary was to read Sir Robert Francis QC's initial report on the scandal at Mid Staffordshire NHS Foundation Trust. I was profoundly shocked by what I read. Here, in our country, in our NHS, patients were being left unwashed in excrement, dementia patients were not being fed or given water and relatives were taking hospital sheets home to wash. His report confirmed the accounts of families who had bravely spoken out – and been ignored by their hospital, the NHS and Whitehall.



A lot has changed since then. Following the Public Inquiry set up by the Government, the NHS has introduced the toughest inspection regime in the world, not just in hospitals but across care homes and general practice too. Over 7,800 more nurses have been recruited to our wards since May 2010, and more than 200 organisations have recently signed up to a safety campaign to reduce avoidable death and halve avoidable harm in three years. And the NHS has been independently rated as the safest healthcare system in the world.

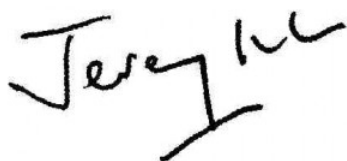
There is much to celebrate – but also no reason for complacency. Changing culture takes time, and we have only just started on the journey. We have also raised our ambition – not only to prevent a repeat of the events at Mid Staffordshire, but also to become the first healthcare system in the world that truly embraces the standards of safety common in the airline, nuclear and oil industries. That means creating a learning culture in which doctors, nurses and frontline staff always feel able to speak out if they have concerns about safety or care.

At the same time the Government has committed itself to implementing the NHS Five Year Forward View to prepare the NHS for the challenges of an ageing population, technological change and changes in patients' needs and preferences. One of the four pillars of our response is to get the culture right: more accountability for patients, more transparency over outcomes and a commitment to put patients in the driving seat for any decisions taken about them.

Many, many people inside the NHS have helped me in this mission and it would be unfair to single out any one in particular. But I would like to mention some of the people who have inspired me: James Titcombe, Julie Bailey, Scott Morrish, Jackie Parkes and Esther Sampson among many others helped me to understand the devastation not just of losing a loved one but also of feeling that the system had closed ranks against you and your family.

I know that every day there are many examples of wonderful care throughout the NHS. But I also know that we have a long way to go if we are going to have a culture that truly reflects the founding values of the organisation. I start every day by replying personally to someone

who has experienced care that has gone wrong, just to remind me of the mountain to climb. This report looks at progress that has been made but also, more importantly, where there is still work to do. I hope it will give encouragement to NHS staff and patients alike that, although there is much progress to make, we are well on our way to being able to say with confidence that the NHS is becoming a patient-centred organisation.

A handwritten signature in black ink that reads "Jeremy Hunt". The signature is written in a cursive, slightly slanted style.

The Rt Hon Jeremy Hunt MP
Secretary of State for Health

Executive summary

Introduction

1. This document sets out the progress that has been made in applying the lessons learned from the tragic and inexcusable failings at Mid Staffordshire NHS Foundation Trust. Much has changed. A new, rigorous inspection regime has been introduced for hospitals, GPs and adult social care – and three Chief Inspectors have been appointed. More than half of acute Trusts have already been inspected. In special measures Trusts, 1,805 extra nurses and nursing support staff have been hired, with 109 more doctors and 129 changes in board-level leadership. There are now over 21,300 more clinical staff working in the NHS than there were in 2010. Although levels of avoidable harm are still too high, more than 94 per cent of patients receive harm-free care. More than five million Friends and Family Test responses have been collected from A&E, inpatients and those using maternity services. And 77 per cent of people say they would feel safe in an NHS hospital if they were very ill – which, although not high enough, still compares favourably by international standards where the NHS was last year ranked as the safest healthcare system in the world.
2. While much has been achieved, the achievements and improvements made since the publication of Sir Robert Francis QC's Public Inquiry report must be sustained and embedded for the future and applied equally and rigorously across all sectors of the health and care system. Each chapter of this document sets out the key areas where further action is needed to ensure that safe, effective and compassionate care is the norm. The online supporting annex to this document sets out in detail the substantial progress made against the 290 recommendations of the Public Inquiry.

Figure – rankings of the UK healthcare system by the Commonwealth Fund in its June 2014 *Mirror, Mirror on the Wall* report

EXHIBIT ES-1. OVERALL RANKING

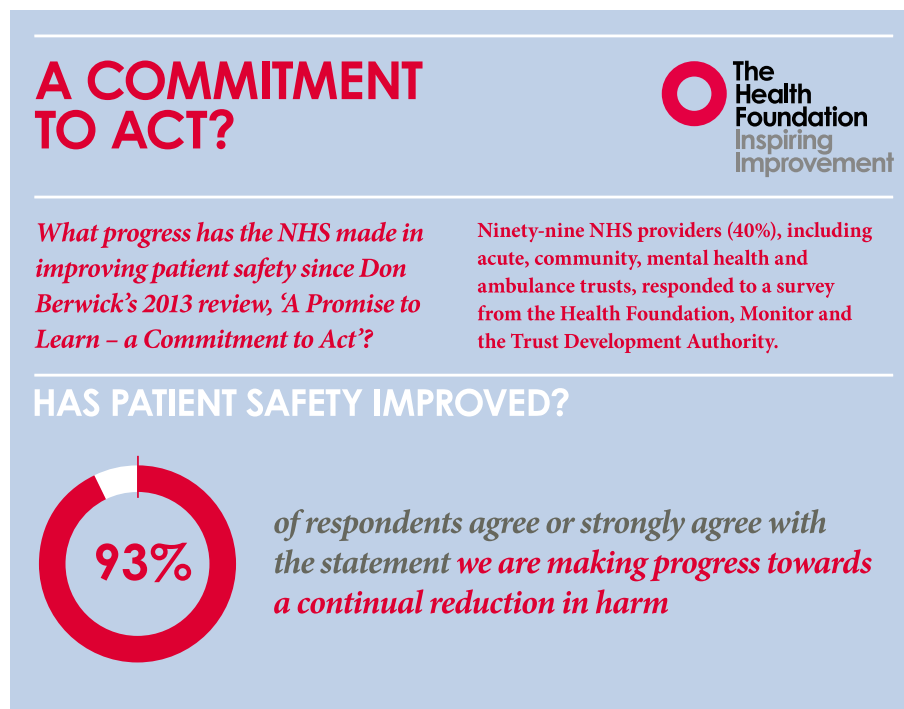
COUNTRY RANKINGS	COUNTRY RANKINGS										
	Top 2*			Middle				Bottom 2*			
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,508

Notes: * Includes ties. ** Expenditures shown in \$US PPP (purchasing power parity); Australian \$ data are from 2010. Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2011; World Health Organization; and Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).

Chapter 1 – Preventing problems

3. Chapter 1 shows how the health and care system has made a fundamental shift in the way in which it prevents the occurrence and recurrence of poor or unsafe care, through:
 - the creation of a much more open and transparent healthcare system; and
 - the launch of a new national drive to improve safety in the NHS.

Figure – percentage of NHS providers who agreed or strongly agreed that progress is being made to a continual reduction in harm



Source: Health Foundation (based on 99 responses to a survey led by the Health Foundation, Monitor and the NHS Trust Development Authority in 2014).

4. The Public Inquiry described how the misalignment of goals, actions and behaviours led tragically to terrible failures of patient safety. In response, the review into patient safety led by international expert Professor Don Berwick called for the NHS to embrace a culture of learning. All the evidence shows that a culture of learning – particularly learning from mistakes – is critical to improving patient safety, and this has been central to the system's response to the Inquiry.
5. The Public Inquiry was scathing about the failure of the Healthcare Commission to notice or act on the appalling standard of care which persisted at Mid Staffordshire, and the regulatory system operated by the Healthcare Commission and its successor the Care

Quality Commission. Sir Robert Francis QC found that the Commission's culture needed to be transformed if it was to be an effective regulator that commanded confidence. Re-establishing the credibility and effectiveness of the Care Quality Commission has therefore been a critical component of the Government response to the Inquiry, seeking to establish the regulator as a trusted, authoritative and independent agency that can quickly identify poor care so that effective action can be taken. The Care Quality Commission has a new Chair, a new Chief Executive and a new board. Three powerful and independent Chief Inspectors have been appointed, covering hospitals, general practice and adult social care. The organisation's independence has been strengthened in legislation. The Care Quality Commission's inspection model has been completely overhauled, moving from a generalist light-touch and tick-box model to a thorough approach, informed by experts, patients and staff, and drawing on a rich set of data to provide assurance that the care provided is safe, effective, well led, caring and responsive.

6. Already the Chief Inspector of Hospitals has inspected more than half of hospital Trusts and is on track to have inspected all by the end of this year.
7. At the same time, there has been an unprecedented drive to ensure that the NHS is the most open and transparent system in the world on key measures of patient safety and patient experience. The Government has placed a new legal duty on all organisations to ensure that, when something goes wrong, patients and their relatives are told about it promptly. Known as the Duty of Candour, it is intended to counteract the legalistic and defensive culture that was found at Mid Staffordshire, fostering instead a culture in which mistakes are acknowledged and learned from. The professional regulators, such as the General Medical Council and the Nursing and Midwifery Council, are introducing consistent responsibilities on individual health professionals so that action can be taken when they are not candid about errors with their patients. This professional accountability is being reinforced through the introduction of the role of the 'responsible clinician'. As a result, already two thirds of Trusts are now participating in the Name Above the Bed initiative, so that patients and their families now know who is in charge of their case, accountable for their care and responsible for ensuring continuity of care.
8. These changes have been made in the context of a much broader and far-reaching programme to open up the NHS. The MyNHS website has been established as a new and powerful tool to assure the quality of care across the NHS. It allows comparison between organisations on 132 different measures that matter to patients – such as safety measures, open and honest reporting, staff survey results, healthcare associated infection rates and hospital food. Importantly, last year – for the first time – it included 11 national clinical audits of the treatment outcomes of individual surgical consultants and further work is under way to extend this to other specialties.

Figure – The MyNHS Website – Comparing Safety Data

Organisation Information	Infection control and cleanliness	Care Quality Commission national standards	Recommended by staff	Safe Staffing	Patients assessed for blood clots	NHS England patient safety notices	Open and honest reporting
Blackpool Victoria Hospital Whinney Heys Road, Blackpool, Lancashire, FY3 8NR Tel: 01253 300000 <input type="checkbox"/> Add to shortlist	OK As expected	! Some standards not met Visit CQC profile	OK Within expected range with a value of 62.39%	91% of planned level	✓ 99.90% of patients assessed	✓ Good - All alerts signed off where deadline has passed	✓ Among the best
Kidderminster Hospital & Treatment Centre Bewdley Road, Bewdley Road, Kidderminster, Worcestershire, DY11 6RJ Tel: 01562 823 424 <input type="checkbox"/> Add to shortlist	OK As expected	✓ All standards met Visit CQC profile	OK Within expected range with a value of 61.52%	94% of planned level	✓ 96.20% of patients assessed	✓ Good - All alerts signed off where deadline has passed	! among the worst
Maidstone Hospital Maidstone Hospital, Hermitage Lane, Maidstone, Kent, ME16 9QQ Tel: 01622 729000 <input type="checkbox"/> Add to shortlist	OK As expected	! Some standards not met Visit CQC profile	OK Within expected range with a value of 68.94%	103% of planned level	✓ 95.20% of patients assessed	✓ Good - All alerts signed off where deadline has passed	OK as expected
Royal Derby Hospital Royal Derby Hospital, Derby, Derbyshire, DE22 3LZ Tel: 01332 340131 <input type="checkbox"/> Add to shortlist	OK As expected	! Some standards not met Visit CQC profile	OK Within expected range with a value of 69.04%	93% of planned level	! 93.40% of patients assessed	✓ Good - All alerts signed off where deadline has passed	OK as expected

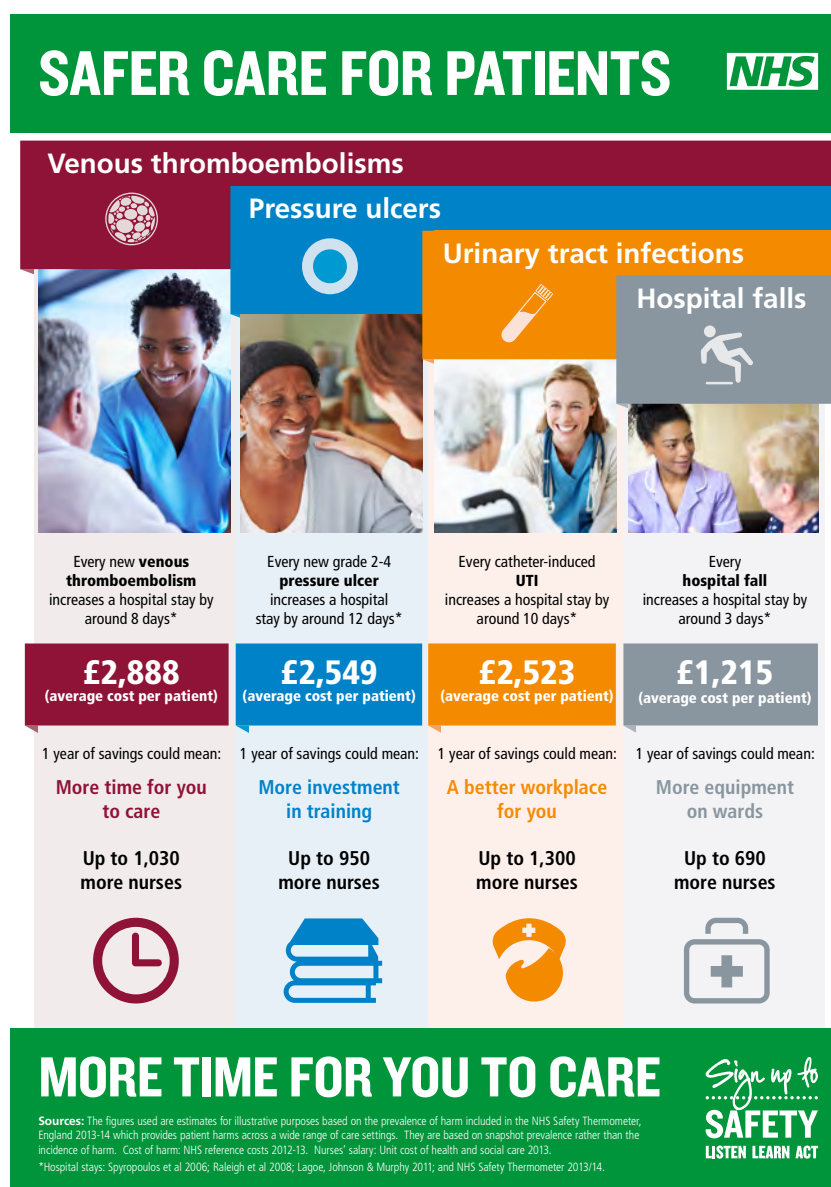
Source – MyNHS.

Note – these results were taken on 6 February 2015 and may have changed since then.

- In a radical move, unprecedented internationally, since the summer of 2014 the NHS Choices website (which hosts MyNHS) has also provided ward-level nurse staffing data on a monthly basis for every hospital in England. In July 2014, the National Institute for Health and Care Excellence (NICE) issued the first of their guidelines to the NHS on how to make the right decisions about nursing staff requirements to provide safe care for patients on adult inpatient wards in acute hospitals. Whereas in the past no one could see the persistently dangerous low staffing levels in Mid Staffordshire, today there is clear national guidance and any failure to follow this would be visible at an early stage and ring alarm bells for the board, the public, commissioners, the media and the Care Quality Commission.
- A critical component of the strategy to prevent harm and avoidable death in the NHS was launched by the Secretary of State at the Virginia Mason Hospital in Seattle, an institution renowned internationally for the systematic and thorough way in which it has

used openness to drive a safer culture of care. The Sign up to Safety campaign, led by Sir David Dalton, Chief Executive of the Salford Royal NHS Foundation Trust, one of England's safest hospitals, is a new movement across the NHS in which organisations and individuals work together with the aim of supporting the NHS to halve avoidable harm and save 6,000 lives by 2017. More than 200 organisations have signed up already and work is now under way to recruit and connect a diverse group of up to 5,000 safety champions from across the healthcare system with safety and quality improvement expertise, to help to improve the safety of care. The campaign is underpinned by 15 new Patient Safety Collaboratives – local networks of hospitals, commissioners and other key stakeholders covering the whole of England, supported by patient safety experts to improve care systematically and weed out harmful practice. NHS England is piloting a Safety Action for England team (SAFE), with the expertise and flexibility to support organisations that are struggling to address critical safety issues.

Figure – Sign Up To Safety poster for use by NHS providers



11. There is still much to do on prevention. For example, as the Sign up to Safety campaign rolls out across the NHS, NHS England will be putting new emphasis on tackling sepsis, a common condition caused by infection which is often missed or treated poorly. Plans to tackle sepsis include new diagnosis and treatment goals for hospitals to help raise standards. In addition the Department of Health is consulting on changes to the NHS Constitution in order to enshrine key safety and transparency principles to underline the importance of open and patient-centred care. To give this teeth, the NHS Litigation Authority will work to ensure that there are stronger incentives to reward financially organisations that are open and safe and the consultation we are launching includes options to require Trusts to meet some compensation costs if they fail to acknowledge mistakes when care is unsafe.

Figure – Signs and symptoms of sepsis from the UK Sepsis Trust



12. It is vital that there is a more open and honest reporting culture in the NHS to protect patients. To do this staff need to feel able to raise concerns at any level in any role across the NHS. This is why the Secretary of State commissioned Sir Robert Francis QC to conduct an independent review to provide independent advice and recommendations on how this could be achieved. The review ran a call for evidence from 7 August to 10 September 2014 seeking input from staff with both good and bad experiences of raising concerns across the NHS, as well as from organisations and employers about their experiences of dealing with staff who have concerns. The outcome of the review, which was fully independent of this Government, was published on the 11 February 2015.

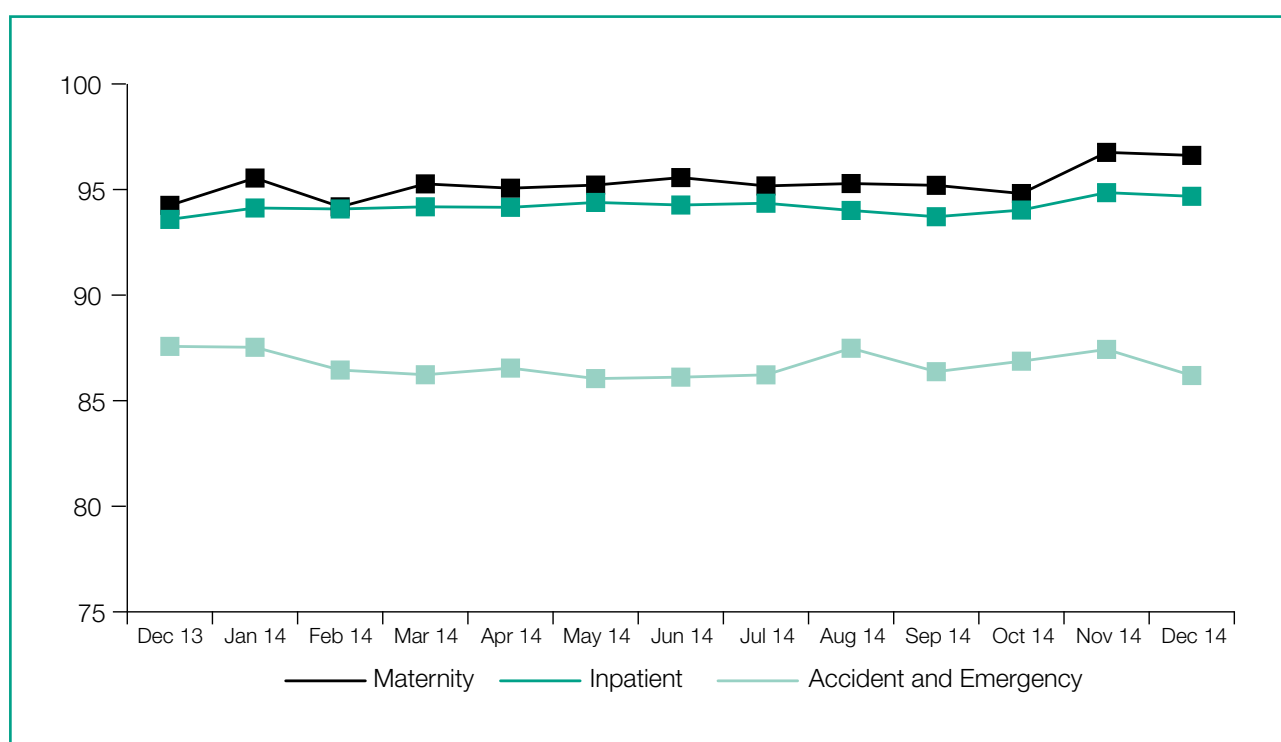
Chapter 2 – Detecting problems quickly

13. One of the more shocking aspects of the events at Mid Staffordshire is the way in which a whole system failed to notice what was happening at the hospital for such an extended period of time. Numb to poor care, there was in places an acceptance of standards that were intolerably low, where cruelty was normalised and behaviour was abusive, dangerous and neglectful. The voice of patients and their families went unheard and obvious warning

signs of something very wrong were unheeded. Chapter 2 sets out the action that has been taken to ensure that complaints about such care are properly heard and learned from, and to ensure that the voice of patients is a strong one throughout the system.

14. In response to the review of complaints commissioned from the Rt Hon Ann Clwyd MP and Professor Tricia Hart, the Department of Health and NHS England issued a new guide for patients on feedback and complaints. The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England have jointly published a new 'vision' or set of expectations which captures what good complaints handling should look like. The NHS has been given access to this guide so that patients can know where to complain and how to get independent support in making a complaint. The Care Quality Commission is now routinely examining how well organisations handle complaints, and those that fall short will have this reflected in their inspection findings.
15. The launch of the Friends and Family Test in April 2013 – asking patients whether they would recommend their hospital to their friends and family – has been a powerful tool at hospital and ward level for clinical teams and hospital boards and for leaders to hear directly what patients think about them. More than five million Friends and Family Test responses have been collected from A&E, inpatients and those using maternity services. An NHS England review found that 85 per cent of Trusts are using it to improve patient experience and 78 per cent report that it has increased the emphasis placed on patient experience in their Trusts.

Figure – Friends and Family Test 'percentage recommend' rates for maternity, A&E and inpatients



Source – NHS England.

16. A strong patient voice is only heard when the system is actually listening and the Public Inquiry found that the Department of Health and its satellites had become too preoccupied with Whitehall and Westminster, detached from the reality in the wards. So following the lead of the Secretary of State and the Ministerial team, who have been spending time on the front line and shadowing clinical colleagues, working shifts on a regular basis, over 500 Department of Health staff, as part of the Connecting initiative, have spent over 4,000 days gaining insight from NHS and social care front-line experience. This learning has been shared across the Department and has been important in reinvigorating the values that brought civil servants to health and care in the first place, and to understanding the impact of national policy on local practice.
17. Looking to future developments, the Department hopes that the recent progress in making the Parliamentary and Health Service Ombudsman more responsive and faster in the way it handles complaints will gather pace and energy and ensure patient and public confidence in its work. It will also continue to discuss with the Care Quality Commission, Healthwatch England, Monitor, the NHS Trust Development Authority and others about how to continue to embed a culture around complaints that is open, learning and wins public and patient trust. In particular, the Government has agreed that a review of NHS complaints advocacy services should be carried out and completed by the spring of 2015. The Government intends to fund local authorities to provide advocacy services, subject to them making information publicly available to a nationally agreed reporting standard about how that funding is being spent.

Chapter 3 – Taking action promptly and ensuring robust accountability

18. Even when problems were identified at Mid Staffordshire, the system was slow to respond. There was confusion about who was responsible for tackling poor care and a lack of accountability when things had gone wrong. Chapter 3 sets out how the Government has put in place a new system with clear accountability and clear standards that force improvement within a fixed timetable. First, having established the Care Quality Commission as ‘the nation’s whistleblower’, with the independence and expertise to speak up when services are poor, failure is now being identified quickly. A total of 19 Trusts have been put into special measures over the past 18 months as a result of this new approach to poor care. This unprecedented willingness to recognise poor care has been critical in starting a journey to improvement, even if it has been unnerving for the NHS for more than 10 per cent of its acute hospital Trusts to be found so wanting.
19. That process of identifying poor care has been strengthened by setting out the fundamental standards of care which it is unacceptable to breach and which can never be tolerated or normalised in a compassionate system with the right culture – the essential things about cleanliness, eating and drinking and consent. Ratings on a four-point scale of ‘Outstanding’, ‘Good’, ‘Requires Improvement’ or ‘Inadequate’ are given to providers for each of the five domains that it inspects. Instead of a system where the timetable for making Foundation Trust status universal meant that not enough attention was being paid to the quality and safety of services, ratings are now key to making decisions over which NHS Trusts should be given Foundation Trust status, with aspiring NHS Trusts having to achieve a ‘good’ or ‘outstanding’ rating under the new inspection regime.

Figure – Ratings published by the Care Quality Commission

	Ratings Published	Cumulative
Oct-Dec 13	1	1
Jan-March 14	4	5
April-June 14	13	18
July-Sept 14	24	42
Oct 14-Jan 15	13	55
Total	55	55

20. The process of recovery from special measures has also been more clearly specified, so that hospitals with complex problems aren't simply put on the 'too difficult' pile, whilst local patients continue to suffer poor care. Intensive support and close scrutiny are making a real difference. Already six hospitals have left special measures and more are on that journey. In special measures Trusts, 1,805 extra nurses and nursing support staff have been hired, with 109 more doctors. In those Trusts that are subject to regulatory action in response to failures in care, change may be required to ensure that the leadership is best placed to drive the required improvements. In the 19 hospitals placed into special measures, there have been 129 changes in board level leadership since the establishment of the special measures regime. Where once poor care and low staffing levels were accepted in parts of the NHS as a necessary evil, they are no longer tolerated anywhere in the system.



Department of Health

New robust, independent inspection has seen 19 trusts enter special measures, 6 turned round, and progress made in nearly all others.

Source: Care Quality Commission / Department of Health



21. Where there is persistent failure to meet fundamental standards of essential care or egregious failings in care, new measures allow for stronger sanctions and criminal prosecutions of both individuals and institutions. A new offence of Wilful Neglect will ensure that individuals who deliberately allow patients to suffer harm can be prosecuted. The introduction of fundamental standards allows the Care Quality Commission to prosecute organisations that are responsible for serious cases of poor care. And a new Fit and Proper Persons Test gives the Care Quality Commission the power to take action against organisations that employ directors who have been complicit in poor care.

“In the rare instances where a practitioner is aware of the risk to their patient, but shows wilful disregard of the risk, they should face a criminal sanction. Such conduct goes against the fundamental tenets of medical professionalism and the ethical duty of care that all healthcare professionals have towards their patients.”

Royal College of Physicians

Chapter 4 – Ensuring staff are trained and motivated

22. In many ways the Mid Staffordshire story was one of a weak board driven by national demands, creating a toxic culture in which meeting targets and balancing the books, not caring for patients, were the primary aim. In his Public Inquiry report, Sir Robert Francis QC found the relentless focus on targets at Mid Staffordshire meant that quality of care and patients' welfare took second priority. Pressure to achieve access targets led to a bullying culture. The Government has put a stop to this. Targets are now harder to meet because the system does not allow a Trust to meet them at the expense of good patient care.
23. Other hospitals are well led, manage to break even and ensure short waits and yet they still provide outstanding care. So ensuring excellent leadership in the NHS has been a key component of the Government's response to Mid Staffordshire and the Care Quality Commission's new inspection regime makes 'well led' one of the five key criteria against which organisations are assessed and inspected.
24. Already the NHS Leadership Academy's Executive Fast Track Programme, starting last June, has been preparing, in partnership with Harvard University, a cadre of talent from clinical practice, business, the army and elsewhere to bolster the top leadership capability of the NHS, ensuring people with the right values and the right skills to lead England's key public sector providers over the coming decades. At the same time Lord Rose of Monewden has been considering in depth how best to ensure the creation of a new generation of leaders who can grow and sustain a leadership culture that sees efficiency as the ally of safety and compassion as the friend of productivity, understanding that poor care is bad for patients, demoralising for staff and bad for the bottom line.
25. These leaders are vital because they will create the context in which more than 1.3 million health professionals will be working. Their views on the quality of care being provided are an important indicator – for boards, the Care Quality Commission and the public – about whether services are up to scratch. The introduction of the Friends and Family Test for staff has

“There was a strong theme running through the interviews with many of the chief executives (and other senior executive figures) reporting that the Francis Inquiry had given them much more traction to champion the cause of quality of care for patients, over and above external pressure to meet targets, whether financial or performance.”

The Francis Report: One year on.
Nuffield Trust, 2014

“A culture of compassion is already present in much of the health and care system: in State of Care 2013–14, the Care Quality Commission reported that its inspection teams saw high levels of compassionate care: patients were generally treated with dignity and respect and were positive about their care and treatment. Inspectors were told across many hospitals that staff were caring, compassionate, polite and helpful. The Care Quality Commission was able to report that most hospitals have caring staff.”

been an important recent innovation, and of those so far surveyed 77 per cent were 'likely' or 'extremely likely' to recommend their organisation to friends or family in need of treatment. The task now is to work to understand and tackle the reasons why almost a quarter of NHS staff are demanding further improvement. They are hungry for change.

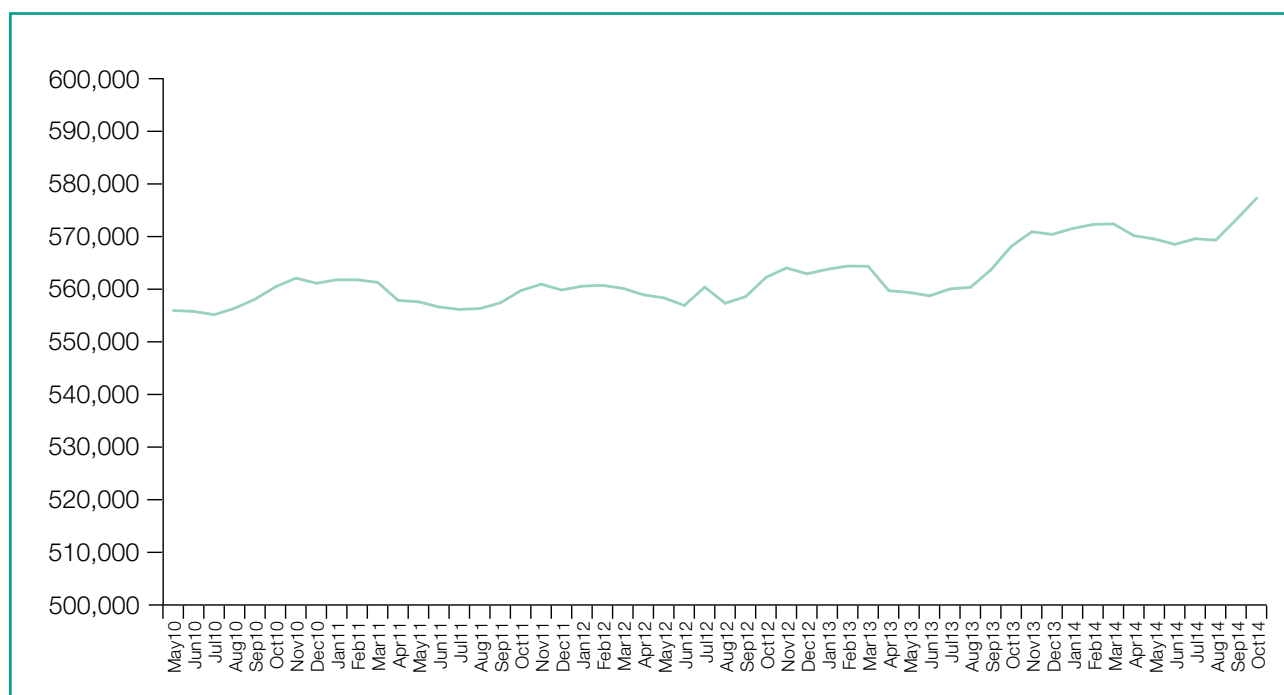
Table – The number of staff surveyed who speak positively about the quality and openness of their work and organisation has improved across nearly all areas since 2010

2013						
Question number	2013 Question Name	2010	2011	2012	2013	How is the score calculated?
<i>Quality</i>						
12a	Care of patients/service users is my Trusts top priority	57.30%	56.30%	62.30%	67.40%	Agree + Strongly Agree
<i>Openness</i>						
18e	When errors, near misses or incidents are reported, my Trust takes action to ensure that they do not happen again	54.90%	54.90%	60.60%	61.50%	Agree + Strongly Agree

Source – NHS Staff Survey.

26. So when NHS staff speak up, it is critical that the system listens with humility and responds with conviction. Since the publication of the Public Inquiry report, and with a new willingness at the centre of the health and care system to hear the reality of failings, the voice of a substantial group of NHS people who have spoken up and suffered as a result has become all the more insistent. While since 2010 the Government has put in place a range of new measures to strengthen the voice of people who speak up for patients, known as 'whistleblowers', there is still a strong sense that the NHS has yet to turn the cultural corner and face up consistently and with humility to the hard truths spoken by its staff.
27. While the right leaders are critical to shaping culture, the Public Inquiry highlighted the need to ensure that the right people are recruited to the health professions. Health Education England recently published guidance to help to ensure that the education providers who are recruiting and training the next generation of health professionals take account of their values as well as their A Levels. In the critical profession of nursing, Health Education England will work with universities to ensure that the recruitment of applicants to nursing degree programmes will include providing evidence of commitment and suitability to a career in nursing. Clinical practice must be scientific to be safe, but it must be emotionally competent to be effective and compassionate.
28. By making the difficult choices needed to foster a strong economy and invest in the priorities that the public really value, the Government has been able to protect the NHS and continue to grow the principal asset of our health service, its clinical staff. It is harder to be caring when you are busy, which is why the Government has put so much emphasis on the NHS and so much emphasis on safe staffing. As a result, there are now over 21,300 more clinical staff working in the NHS than there were in 2010.

Figure – Professionally qualified clinical staff working in the NHS (full time equivalent)



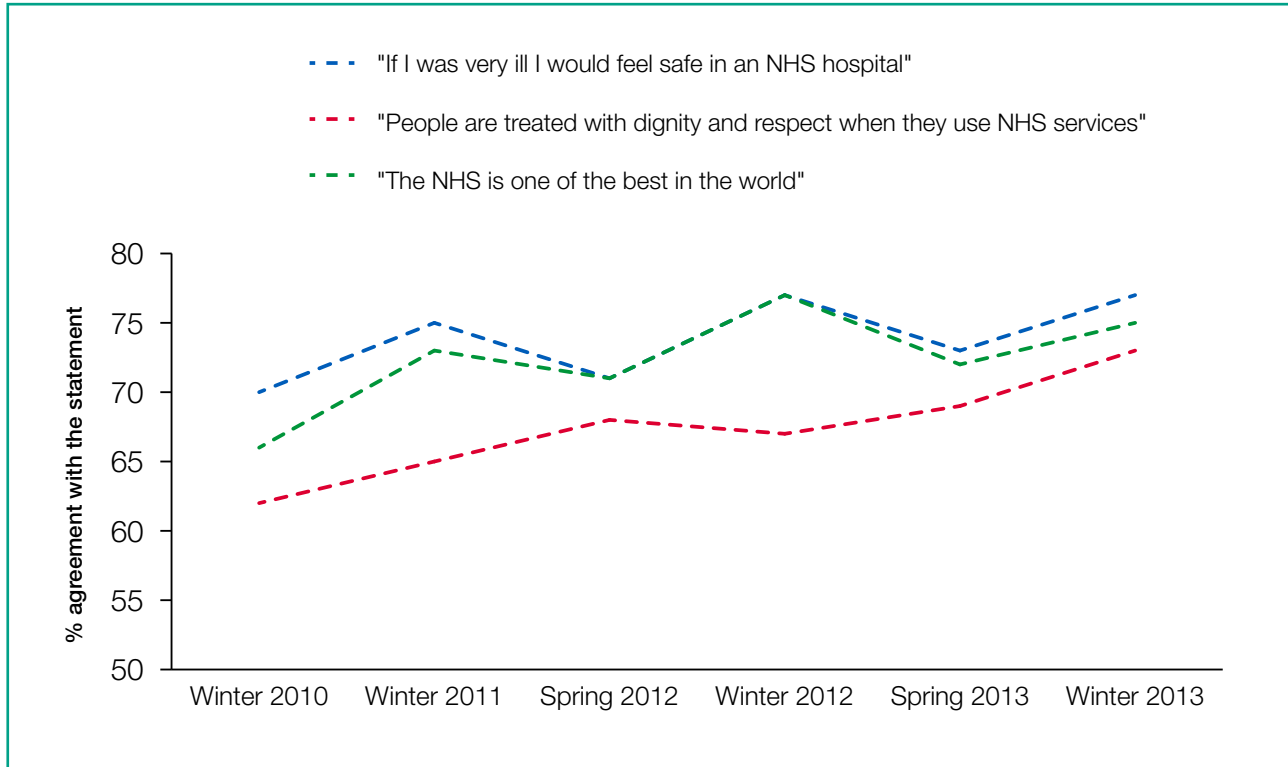
Source: HSCIC monthly NHS Hospital and Community Health Service Workforce statistics in England.

29. Further work will be needed in the light of Sir Robert Francis QC's *Freedom to Speak Up* Review to ensure the right professional and institutional culture in the NHS, but with the clinical workforce growing it has been heartening to see the way in which NHS staff have embraced the lessons from the Public Inquiry to reaffirm their professional values and their commitment to safe, effective and compassionate care.

Conclusion

30. A great deal has been achieved since the publication of Sir Robert Francis QC's landmark Public Inquiry. This document's companion progress report on the 290 recommendations gives a detailed account of action and implementation across the whole of the healthcare system. That is important, but perhaps the most important point is that the ongoing need to change the culture in the NHS to one of patient-centred, continual improvement in care and safety. Mid Staffordshire was a profound shock to the system. Hard truths have been faced. While the challenges facing the NHS are, as they always are, complex, the determination to meet them in a way that secures and strengthens its fundamental purpose – safe, effective, compassionate care for all it serves – has been renewed as its simple, guiding truth.

Figure – The NHS today – the public’s verdict



Chapter 1 – Preventing problems

Achievements in the past two years

- Unprecedented levels of transparency on safety through the MyNHS website.
- Publication of nurse staffing levels, backed up by national guidance.
- Sign Up To Safety – a new national drive to halve avoidable harm, saving 6,000 lives in the process.

Next steps

- The Care Quality Commission found in its *State of Care* report that many providers have not got to grips with the basics of safety. This makes all the more urgent the need to make progress on patient safety, both nationally and internationally.
- There is a new focus on tackling sepsis, but more is needed.



“Since Francis and the Hard Truths report it has made the discussions about quality at the Board and throughout the Trust even easier than it was before. It doesn’t make the decisions easier but it does mean you take them for the right reasons. As we move forward I welcome the need for openness and transparency and in particular growing the strength of professionalism in the nursing and midwifery workforce through the implementation of revalidation.”

Dame Eileen Sills, Chief Nurse, Director of Patient Experience, Guy's and St Thomas' NHS Foundation Trust

Transparency and safety

- 1.1 The NHS has made remarkable progress on transparency since publication of the Public Inquiry report. It is now leading the world in putting as much comparable information about services as possible into the hands of patients and the public. The launch of the MyNHS website last year provided a one-stop site where patients, professionals, the public and NHS leaders can compare the performance of services across health and care, over a range of 132 measures including monthly actual and planned staffing levels by hospital ward, which can be compared to local and national levels. This ground-breaking initiative will be a key weapon in the future in the fight against poor care, enlisting the power of data for the cause of patient safety. While patients, the public and the media will be able to question their services about aspects of care which appear to fall short, putting pressure on organisations to up their game, for Trust boards and professionals it will be an important tool for assessing how well they are doing compared with other bodies and a spur to improve.

- 1.2 As part of this radical drive to use data to improve performance there have been a number of further important steps to open up the NHS. In the past, the NHS collected data on ‘never’ events, but only published them annually (never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented, for example operating on the wrong side of the body). As a further step in transparency, since December 2013 NHS England has been publishing provisional never events data quarterly, and from April 2014, for never events reported as occurring during 2014/15, NHS England is publishing the data as monthly updates.
- 1.3 Importantly, the NHS is now also leading the world in publishing consultant-level data. For the first time ever, patients can see data about 6,515 different consultants in one place. The Consultant Outcomes Publication (COP) began with ten national clinical audits in June 2013. Consultant data for neurosurgery and upper gastro-intestinal surgery have also now been published. This is just the start of a long-term programme to make much more transparent the clinical performance of NHS staff, and NHS England is looking into which outcomes data could be most usefully and feasibly collected to extend the programme.
- 1.4 This is a critical moment for transparency in the NHS. The Public Inquiry highlighted the importance of openness, candour and transparency with patients and the public. To ensure that transparency is hardwired into the way in which the health and care system sets its objectives and accounts for them the National Information Board will collate and present annually to the Secretary of State for Health proposals for changes to the data to be collected and the metrics made available on My NHS to improve services, taking account of factors including the need to reduce burdens. The Care Quality Commission and its Chief Inspectors will report annually to the Secretary of State for Health with their assessment of how well the NHS is doing in taking forward the recommendations on both the Public Inquiry and the Freedom to Speak Up review. The National Information Board and Care Quality Commission reports will be public and copied to the Health Select Committee. The Secretary of State will respond annually.



“When I visit trusts around the country it feels different from a year ago: boards are now wanting to know about the variation in their hospital, between different wards – they are genuinely interested in understanding how they might know how safe their trust is and they are more comfortable with reporting what is actually occurring. There has also been significantly more attention given to assuring safe nurse staffing levels and to finding ways to engage more meaningfully with frontline staff.”

*Sir David Dalton, Chief Executive,
Salford Royal NHS Foundation Trust*

- 1.5 Recent studies suggest that on average each week there is one avoidable death for every hospital in England. Whilst, on the face of it, so many deaths is shocking, this rate of avoidable mortality is similar to those of health care systems in other developed countries. But that should not be a source of complacency, because as a unified national system the NHS is uniquely placed internationally to use information and cooperation to make rapid in-roads in reducing the number of avoidable deaths.
- 1.6 To do so, individual organisations need a much better sense of how their organisation might contribute to the national figures, and a sense of whether, year on year, they are making progress. To address this, each year we will commission a retrospective audit of patient care in a representative sample of hospitals to estimate the number of avoidable deaths that occur across the NHS. This will be repeated on an annual basis. We will further commission work to understand how the number of avoidable deaths may vary between organisations and what other indicators may robustly predict the number of avoidable deaths. We will then publish a best estimate of the number of avoidable deaths for each Trust by the end of March 2016. Determinants of this predicted avoidable mortality rate may include the safety performance of each hospital as revealed by Care Quality Commission safety ratings or other indicators where research indicates a valid correlation. The Chair of every Trust board will send an annual letter to the Secretary of State for Health about how their Trust plans to reduce avoidable mortality.
- 1.7 In addition we will work with professional organisations and data experts to identify the five areas of clinical care in which reducing measurable avoidable mortality is most critical. Every hospital will be provided with risk adjusted outcomes data for these areas in order to guide focussed action on reducing avoidable deaths.
- 1.8 At the same time we will commission further work with a view to extending data on avoidable deaths to deaths outside of hospital and commission research on the feasibility of producing rates of avoidable harm.

Table – NHS safety Thermometer Summary Results

	April 2012	December 2013	December 2014
Harm Free	89.7%	93.5%	94.1%
Pressure Ulcers (All)	7.0%	4.7%	4.3%
Falls with Harm	1.3%	0.8%	0.7%
UTIs in patients with Catheter (All)	1.6%	0.9%	0.8%
VTE (new)	1.0%	0.4%	0.4%
Patients	86,453	206,641	193,894
Organisations	212	847	770

Source: NHS England

Transparency – safe staffing

- 1.9 Chronic under-staffing of wards at Mid Staffordshire to meet national financial goals was a key component of the pressures that led to such horrific treatment of patients there. The Berwick Review into patient safety commissioned by the Government in response to the Public Inquiry recommended that “staffing levels should be consistent with the scientific evidence on safe staffing, adjusted to patient acuity and the local context”.
- 1.10 To support this, in July 2014 the National Institute for Health and Care Excellence (NICE) issued the first of their guidelines to the NHS on how to make the right decisions about nursing staff requirements for safe care on adult inpatient wards in acute hospitals, and in October NICE endorsed the first toolkit to support implementation of the guidance. NICE will be developing further guidelines on safer midwifery staffing in maternity settings, in A&E, and in mental health inpatient and community nursing settings.
- 1.11 In addition, the Chief Nursing Officer has developed a guide to allow providers to identify the ‘care’ hours their staff are spending with patients and service users. This sits alongside the National Quality Board guidance, NICE guidelines and NICE-endorsed safe staffing toolkits to give providers additional support in making decisions to secure safe staffing care.
- 1.12 While the Care Quality Commission will be monitoring staffing levels as part of its inspection and ratings regime, given their importance to ensuring safe and compassionate care the Government took the radical step of asking NHS England to collect and publish every month, for every organisation, ward-level data on safe staffing. This has been available since June 2014, so not only do all boards now have the data to hand to monitor their own staffing levels, but patterns of sustained understaffing of the type that occurred at Mid Staffordshire can also be highlighted. While ‘more staff’ is too crude an answer to poor care, there is no doubt that in parts of the country some hospitals and some wards were risking quality by constraining staff costs too tightly. That there are now over 7,800 more nurses working on the wards than in May 2010 is an indication that the NHS has responded to the Public Inquiry report and invested in the staff needed to ensure safe care.



“I believe that the introduction of the new Duty of Candour is potentially the biggest advance in patient safety and patients’ rights in the history of the NHS. It stems directly from the experience and priorities of patients and families, who have suffered avoidable harm and not been told the truth.”

Peter Walsh, Chief Executive, Action Against Medical Accidents (AvMA)

Individual and institutional transparency – the Duty of Candour

- 1.13 This national emphasis on transparency has been complemented by work to ensure that both organisations and staff are open about mistakes when things go wrong. The Government has delivered its commitment to introduce a new statutory Duty of

Candour. This places a duty on all organisations to ensure that, when something goes wrong, patients and their relatives are told about it promptly. It is intended to counteract the legalistic and defensive culture that was found at Mid Staffordshire, fostering instead a culture in which mistakes are acknowledged and learned from. The Duty of Candour came into force for NHS bodies in November 2014 and will be extended to all providers registered with the Care Quality Commission in April 2015. Guidance on the duty was published by the Care Quality Commission in November 2014.

- 1.14 There was much debate on whether the legal duty should also apply to individual clinicians as well as to organisations. The Government agreed with the General Medical Council and the Nursing and Midwifery Council that they would work with the other professional regulators to develop a consistent approach across the healthcare professions on a new professional Duty of Candour. A joint statement to take this forward was issued in October 2014 and the General Medical Council and the Nursing and Midwifery Council have also developed joint explanatory guidance for the NHS for the professional Duty of Candour and launched a public consultation on this in November 2014. The Nursing and Midwifery Council has also developed and consulted on a new code for nurses and midwives. Together, these changes will support the NHS in building an open culture where staff can be confident that they can speak up for the patients in their care without repercussions.
- 1.15 In addition the NHS Litigation Authority has issued guidance to the NHS on how to apologise to patients who have experienced harm and has reiterated, in support of the Duty of Candour, that an apology is not an admission of guilt, but the right thing to do.

Sign up to Safety

- 1.16 This drive for greater transparency is important for its own sake, making the service and its staff more accountable for what they do, but it also has a powerful and deep-seated cultural role in creating the open learning environment which is the critical context for ensuring consistently safer care, reducing harm and avoiding preventable deaths.



“Having watched the story of Mid Staffordshire unfold, there are unmistakable parallels with events at Morecambe Bay, where my son died due to avoidable failures in his care in 2008. Since then, I’ve experienced how defensive and closed the NHS can be and what the consequences are when concerns about the safety of services are kept quiet. One year on from the government’s response to Francis, there has been significant change. Although there is still a long way to go, it now feels like we’ve reached a real tipping point for patient safety and that the foundations for real and sustainable change are now in place.”

James Titcombe, National Advisor on Patient Safety, Culture & Quality, Care Quality Commission

1.17 In March 2014, the Secretary of State for Health issued a call to action to make the NHS the safest healthcare system in the world and achieve a three-year goal to halve avoidable harm and save 6,000 lives. The Sign up to Safety campaign seeks to harness the energy, commitment and ingenuity of the NHS to put safety front and centre of health and care, building a movement for change that speaks directly to the basic reasons that many NHS staff had for coming into the NHS in the first place.

Figure – Sign up to Safety poster for use in NHS providers

SAFER CARE FOR PATIENTS **NHS**

Pressure ulcers

A new grade 2-4 pressure ulcer can mean:

- ✗ **12 extra bed days for the patient**
- ✗ **£2,529 in costs per case**
- ✗ **Possible complications**

Reducing avoidable harm could mean:

- ✓ **Shorter hospital stays**
- ✓ **Savings to fund up to 950 nurses**
- ✓ **More time to care**

"From the board to the ward, we all have a duty to speak up for safer care. If you can see a safer or more efficient way of looking after patients, then speak out. It's not always easy, but it costs us all."

Helene Donnelly OBE
Ambassador for cultural change
Staffordshire and Stoke on Trent Partnership NHS Trust

MORE TIME FOR YOU TO CARE

Sign up to
SAFETY
LISTEN LEARN ACT

Sources: The figures used are estimates for illustrative purposes based on the prevalence of harm included in the NHS Safety Thermometer, England 2013-14 which provides patient harms across a wide range of care settings. They are based on snapshot prevalence rather than the incidence of harm. Cost of harm: NHS reference costs 2012-13. Nurses' salary: Unit cost of health and social care 2013.
*Hospital stays: Spyropoulos et al 2006; Raleigh et al 2008; Lagoie, Johnson & Murphy 2011; and NHS Safety Thermometer 2013/14.

1.18 The campaign brings together local safety leads and agents for change, reaching out to all care providers in all care settings, including general practices. Organisations that sign up set out what they will do to strengthen patient safety, including a response to five key pledges and a safety improvement plan that shows how their organisation intends to save lives and reduce harm for patients over the next three years. The five key pledges are Put Safety First, Continually Learn, Honesty, Collaborate and Support.

- 1.19 Organisations are being encouraged to focus on a few key areas and track their progress by applying measures that are standardised, simple and in widespread use already. The campaign will build a community of safety experts who will support organisations to enhance capacity and capability in the NHS for safety improvement. To date over 200 organisations have signed up to safety.

National Patient Safety Collaborative Programme

- 1.20 The Berwick Review recommended the development of regional or sub-regional networks of NHS organisations across the country which could collaborate on improving the safety of services. In response, NHS England and NHS Improving Quality have led the design and delivery of a new National Patient Safety Collaborative Programme which will be the main practical vehicle for the safety campaign on the ground. Launched in October 2014, there are 15 Patient Safety Collaboratives aligned with and led by each of the Academic Health Science Networks. Established as learning and improvement networks, and collectively probably the largest in the world, the Collaboratives will work with their healthcare communities to focus on the actions that can make the biggest difference to patients in every part of the country and systematically tackle the leading causes of harm. The aim is that, by the end of March 2019, every provider and commissioner of NHS-funded care will be involved, delivering a significant increase in the patient safety improvement capability of the NHS.
- 1.21 Two core priorities of the National Patient Safety Collaborative Programme are leadership for safety improvement and developing a national safety measurement strategy. This means identifying the interventions that work and helping to spread them. Patients will be increasingly involved in fostering a patient safety improvement culture in the NHS.



“The commitment to safety is clear. The work in England represents a systems view, from finding ways to hear the patient’s voice, to working to a culture of transparency, to building a learning system to share best practices quickly. A key to progress will be the building of improvement capability widely across the ‘5,000 patient safety fellows’ and beyond. With shared data and the skills needed to make changes from the bedside to the board rooms, patients and their families can expect safe and person-centred care.”

Maureen Bisognano, President and CEO, Institute for Healthcare Improvement

Building a culture of improvement

- 1.22 NHS England is working with the Health Foundation to take forward the compelling case in the Berwick Report to organise a national system of NHS improvement ‘Fellows’, to recognise the talent of people with improvement capability and to link them and support their patient safety improvement work, whether in their own organisations or by working

on issues that will help other organisations or the whole system. The initiative will connect safety experts to spread learning and skills across the NHS. It will also include opportunities for patient representatives and community champions who have helped to improve safety.

Location of national safety functions

- 1.23 Sir Robert Francis QC proposed in Recommendation 97 of his report that consideration should be given to transferring national functions on patient safety to a single systems regulator.
- 1.24 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.
- 1.25 The Department of Health will therefore consider with relevant organisations the options for transferring NHS England’s responsibilities for safety to a single national body.

Health education for safety

- 1.26 The Berwick Review recommended that all healthcare professionals should “receive initial and ongoing education on the principles and practices of patient safety, on measurement of quality and patient safety, and on skills for engaging patients actively”. This is the responsibility of a number of organisations, which have been working together over the last year to embed patient safety knowledge and skills at all stages and levels of education, training and professional development.
- 1.27 Students and clinicians in training are the eyes and ears of the service today and the safety leaders of the future. They need to be trained not only in safe care of the patient in front of them – already central to training – but also in all the elements that are crucial to creating safer clinical systems: understanding human factors, measurement and audit, effective multidisciplinary team working, safe handovers of care, learning from errors and near misses, and the tools of improvement science.
- 1.28 The key actions being taken to ensure that safety is at the heart of education, training and professional development are:
 1. Developing a series of training films to support speaking up in care settings. These films are being developed by Health Education England with the support and advice of Helene Donnelly using her knowledge as Ambassador for Cultural Change at Staffordshire and Stoke on Trent Partnership NHS Trust. The first film has now been made available and is focused on raising concerns. Future films, which will be issued in the coming weeks, will deal with how to respond to concerns, and how to support staff to raise concerns.

2. Action to make human factors integral to the way clinicians learn and think about care. This includes a campaign launched this month in association with Patient Safety Collaboratives and academic health science networks to promote the role of human factors in improving safety.
3. The Health Education England Commission on Education and Training for Patient Safety, jointly chaired by Professor Sir Norman Williams and Sir Keith Pearson, Chair of Health Education England, will set out comprehensive proposals for enhancing safety training for all health and care professionals. The Board will report in autumn 2015 and will set out recommendations against four themes:
 - Education and training about how to raise concerns about patient safety
 - Education and training in human factors for patient safety
 - Utilising mandatory training to improve patient safety
 - Education and training in service improvement to improve patient centred outcomes and patient safety.

1.29 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.

1.30 As the system regulator, patient safety is at the heart of the General Medical Council's standards for undergraduate medical education, which place strong emphasis on safe supervision and practice. Patient safety will continue to be a central feature of the new single set of education standards for all stages of education and training which they will introduce this year.



“Hard Truths provided the focus and opportunity to create lasting legacies that will continue to change the culture of the NHS and improve the safety of our patients long into the future. With comprehensive new programmes such as the Patient Safety Collaboratives now in place, we are creating the infrastructure to support and nurture a renewed surge of enthusiasm for safety that will soon bear fruit at every level and in every healthcare setting. There is lots of hard work still to be done but we now have the conditions to build on this momentum to not only ensure tragedies such as Mid Staffordshire never happen again but to make safety in the NHS the envy of the world.”

Dr Mike Durkin, Director of Patient Safety, NHS England

- 1.31 The General Medical Council is working with the Academy of Medical Royal Colleges to develop a framework to strengthen the generic content of training, particularly in areas which relate to human interaction and behaviour and the relationship to patient safety – for example, communication with patients and colleagues, shared decision making with patients and families, teamwork and inter-professional learning.

Reporting and responding

- 1.32 Organisations with a culture of safety are hungry for data as a source for improvement. They understand the value of learning from errors and adverse incidents. The Berwick Review recommended a number of measures to ensure effective reporting of serious incidents and prompt action in response. To improve the response to incidents and risks, a new National Patient Safety Alerting System was launched in January 2014. The system's design is based on the models used in other high-risk industries and disseminates patient safety information to the front line so that urgent safety issues can be rapidly addressed. Seventeen alerts have been issued in the past year.
- 1.33 NHS England also published a Serious Incident Framework in March 2013, which gives the NHS guidance on how to manage Serious Incidents; it is currently refreshing this to reflect operational feedback on implementation.
- 1.34 Further key collaborative initiatives on the patient safety agenda include the Surgical Never Events Task Force Reference Group, which will produce standards for operating departments, and the national programme for Technology Enhanced Learning. Both initiatives include a strong focus on understanding how human factors and professional behaviours contribute to safer care.
- 1.35 A pilot for a new patient safety intensive support team – Safety Action Force England (SAFE) – is being established to learn how best to provide short-term support to individual Trusts that have identified patient safety challenges. It will be launched shortly. Based on sound, well respected safety principles, adapted from industry best practice and developed over the past decade for application in the healthcare environment, SAFE will provide Trusts with access to patient safety expertise and support in tackling safety issues.



“This constellation of investments and activities represents serious commitment to evolving the NHS fully as a learning organization committed to the never-ending pursuit of safer care. The use of learning collaboratives and the development of a large cadre of NHS staff and professionals fully skilled in the scientific principles and practices of safety are welcome, indeed. Paired with ongoing commitments to total transparency and to patient, carer, and community involvement, these investments will pay off in lives saved, harms averted, and growing confidence in the NHS.”

*Professor Don Berwick former
President and Chief Executive
Officer of the Institute for Healthcare
Improvement*

Safety surveillance

- 1.36 In addition to these arrangements for reporting local incidents nationally, work has been underway to ensure that national bodies are much more effective at spotting emerging problems. There is a determination not to repeat the events at Mid Staffordshire where, for many years, national bodies failed to notice or act upon sustained poor quality care. As part of this, NHS England and the Care Quality Commission have been developing a set of patient safety measures for use by the Care Quality Commission in their surveillance model, and NHS England has provided patient safety expertise on how patient safety data might be used for surveillance and inspection.
- 1.37 Under an enhanced monitoring process, the General Medical Council is also encouraging Local Education and Training Boards and deaneries – and individuals – to highlight persistent and serious patient safety concerns in training environments. Their National Training Survey, completed by all doctors in training, includes questions about reporting patient safety concerns and acts as a lever to improve safety. Through the survey, the General Medical Council encourages local reporting so that action is taken promptly. All the concerns raised are now investigated by Local Education and Training Boards, deaneries and local education providers, and the changes made are reported back to the professional regulator. For the next survey, the General Medical Council will be adding questions designed to tell how effectively doctors in training feel they are able to raise patient safety concerns locally and how confident they feel about action being taken and lessons learnt.
- 1.38 Throughout this coming year, the General Medical Council will carry out a series of targeted site visits in response to bullying and undermining concerns raised in this year's survey. These will examine how particular departments are managing risks and support them to learn from the experience of services which have successfully tackled undermining and bullying. It will report the findings early in 2015.
- 1.39 The General Medical Council is also considering ways in which it can contribute to the identification and investigation of system or generic concerns. At the end of March 2014, the General Medical Council began publishing information about education concerns that are subject to enhanced monitoring by the organisation. Such cases relate to patient safety or quality of education issues in a local education provider and can come from a variety of sources (including visits, routine monitoring, Local Education and Training Boards and Deanery Reports).

The General Medical Council's National Training Survey 2014 showed that, of all respondents, 88.1 per cent said they were told who to talk to in confidence if they had personal or educational concerns compared with 85.4 per cent in 2013. The national score for handover – crucial for ensuring the quality and safety of patient care – had risen slightly in 2014 (from 66.0 to 67.8) with big rises in emergency medicine (from 52.2 to 58.0) and ophthalmology (from 39.0 to 43.3) posts. For specialties that use handover, scores for handover have not dropped. Scores for handover have increased across all stages of training.

Freedom to speak up

- 1.40 Since the publication of the Public Inquiry report the landscape of policy and legislation to ensure safe, effective, respectful and compassionate care has been transformed. The inspection regime has been overhauled and a programme of robust, expert, thorough and independent inspection is now being rolled out across health and social care services in England. New sanctions, fundamental standards and tighter and tougher accountability have brought a harder edge to the assurance of good care. The beginning of a revolution in transparency about quality of care is bringing the power of open access to comparative data to bear on the priorities and consciousness of those who govern and lead in health and social care.
- 1.41 These changes are necessary, but they are insufficient on their own to secure the consistency of experience and reliability of care that patients should be able to take for granted and which staff are striving to provide. The remaining critical component is culture. Since the publication of the Public Inquiry report, the NHS has undoubtedly made progress in strengthening its culture, but a great deal more remains to be done. In an organisation as large and as complex as the NHS – operating under pressure, under intense scrutiny and in which life or death decisions are made every day – no matter how strong the professional instinct to do the right thing, no matter how powerful the impulse to care, there are inevitably times when it might feel easier to conceal mistakes, to deny that things have gone wrong and to slide into postures of institutional defensiveness.
- 1.42 All large institutions operating in high risk environments are vulnerable to this phenomenon, so it is vital that leaders are alert to the risks and actively work to promote the culture of openness, learning and professional and institutional humility which is the absolute bedrock of safe care.
- 1.43 The most important resource available to the NHS is its staff, and one of the key lessons of the Public Inquiry, but also the work of the Keogh Review and of the new, rigorous inspections undertaken by the Care Quality Commission is the importance of listening to staff. When they raise concerns, they very often know when things



“Since the publication of the Francis Report I have been hugely encouraged by responses and efforts made to address cultural change throughout the NHS. The results of this will certainly take time to come to fruition; however, there have been many positive improvements already.

“Working to help support health and social care staff raise concerns as I do, I have witnessed an increase in staff bravely speaking up who would not have felt able to do so before. The direct result of this has been improvements made to patient and staff welfare. There is still a very long way to go, but I know that by truly consulting with, communicating with, valuing and respecting staff, they will feel empowered and enabled to change cultures. Those who see fit to block this progress will add no value to the NHS.

“This is a responsibility for all of us and we must support each other in order to really achieve it. The momentum is growing.”

Helene Donnelly OBE, Ambassador for Cultural Change, Staffordshire and Stoke on Trent Partnership NHS Trust

are not working well, and when care is not safe. In good organisations, staff concerns are listened to and, where necessary, acted on as part of normal operations. In the best organisations, they are singled out for praise for doing so.

- 1.44 There are, of course, always situations when the 'normal channels' are not effective or appropriate, and an individual feels obliged to 'blow the whistle'. Whistleblowing plays an important role in raising issues and holding organisations to account across many sectors of life, such as the aviation and off-shore oil industries and the NHS. While there are some areas of good practice in the NHS, all too often staff raising concerns feel that they are not taken seriously, and those who blow the whistle can feel isolated and undermined.
- 1.45 The Government is determined that the NHS should be the safest and most transparent healthcare system in the world. To achieve this, individuals must feel safe to raise the alarm about matters which are in the public interest and be confident that action will be taken when concerns are raised.
- 1.46 The Public Inquiry exposed shocking, unacceptable levels of patient care and a toxic and intimidating management culture which deterred staff from raising concerns. Although vulnerable patients were being left in their own excrement, or deprived of water, when concerns were raised in good faith they were ignored, and staff were vilified for speaking up. There was no recognition or understanding of the important part that staff play in improving and ensuring acceptable levels of patient care. The board had lost its moral sense of priority and refused to listen to its own people about the neglect and suffering that it was presiding over. There was an instinct to deny rather than to learn, to defend rather than to improve, which created an organisation that was out of touch with the horrific reality of poor care occurring on their watch.
- 1.47 The Government has introduced a number of measures to make it easier for those working within the NHS to raise concerns. These include:
- Issuing unequivocal guidance to NHS organisations that all their contracts of employment should cover staff whistleblowing rights;
 - The publication of new guidance by the Whistleblowing Helpline in March 2014;
 - Adding the health and social care regulatory bodies, NHS Trust Development Authority and auditors of Foundation Trusts to the Prescribed Persons list, increasing the number of organisations to which staff can blow the whistle;
 - Applying the concept of vicarious liability to the whistleblowing legislative framework. This means that where there is any bullying or harassment of a whistleblower by a fellow worker, this is treated as being done by the employer;
 - The Secretary of State writing in March 2014 to all Chairs in NHS Trusts and Foundation Trusts in England, to reiterate the vital importance of fostering a culture of openness and transparency in the NHS in which concerns about care can be raised, investigated and acted upon.

- 1.48 While the culture at Mid Staffordshire was particularly disturbing, it is important to recognise that in other parts of the NHS – in some wards and in some weaker institutions – there were also worrying cultures that were failing to face up to problems and deal with them, letting down patients and staff alike.

Freedom to speak up

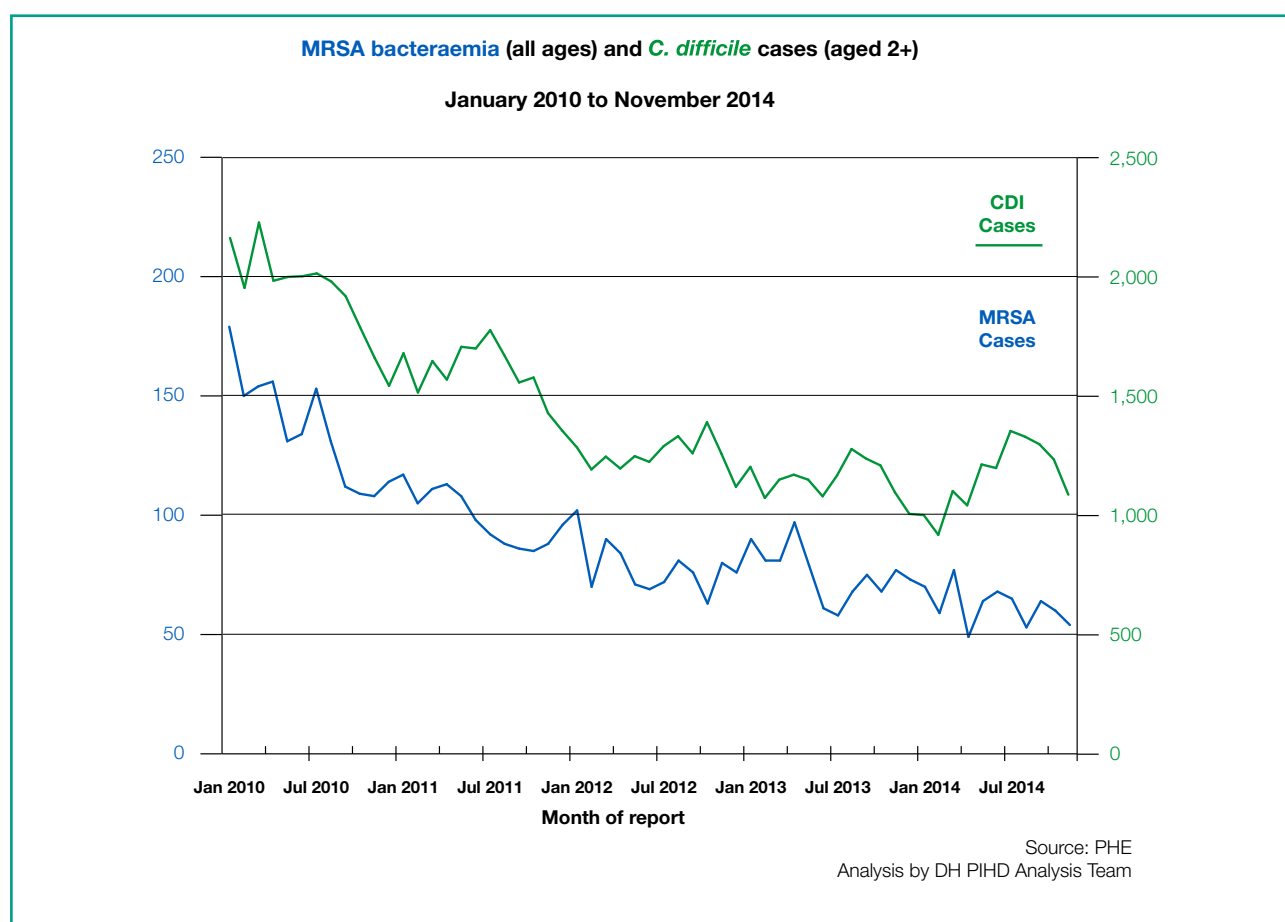
An independent review into creating an open and honest reporting culture in the NHS

- 1.49 The Secretary of State for Health therefore commissioned Sir Robert Francis QC to carry out an independent policy review, called *Freedom to Speak Up*, in order to provide independent advice and recommendations on creating a more open and honest reporting culture in the NHS. The Government is grateful to Sir Robert for the thorough and thoughtful consideration he has brought to this area, and also to the hundreds of current and former staff who have told often distressing and disturbing accounts of their treatment at the hands of a system that too often appeared unwilling to listen or was hostile to any challenge. Such experiences cannot be undone, but it is vital that they are learned from.
- 1.50 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 experiences 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.
- 1.51 The review is being published alongside this report, and the Secretary of State for Health will set out the Government's response.

Still to do – next steps on preventing poor care

- 1.52 The health and care system has shown that it is ambitious to improve safety and much has been achieved in the last year to build a culture of safety. Internationally, the NHS is regarded as a world leader on patient safety, given its ability to develop and maintain comprehensive patient safety systems and processes on a system-wide basis. The UK is in the leading group of EU countries that have implemented 11 out of 13 of the EU Council's Recommendations on Patient Safety and Health Care Associated Infections. The Commonwealth Fund Study ranked the NHS as the safest healthcare system in the world overall and first for patient-centred care (compared with seventh in 2010).

Figure – Monthly HCAI trends in England



- 1.53 But it is clear from the Care Quality Commission's *State of Care* report that there are also significant variations in safety and scope to improve healthcare standards universally and reduce avoidable harm. Delivery of healthcare is also constantly evolving, and many services that in the past were restricted to hospital settings are now being delivered in the community. The challenge of ensuring a relentless focus on safety and continuous improvement is therefore as relevant to the non-acute sector and social care as it is to acute hospitals. The report concluded that too many providers have not got to grips with the basics of safety. The most recent published research using retrospective case studies of adult deaths estimates that approximately 12,000 deaths have at least a 50 per cent chance of being avoided. While this level of harm is consistent with international comparators, it is nonetheless a stark picture of needless suffering and loss which makes all the more urgent the need to make progress on patient safety, both nationally and internationally.
- 1.54 Our ambition is to have a health and care system with levels of safety akin to those in the airline industry. As a culture of safety is extended and embedded, there are a number of areas where the health and care system is being supported to improve.
- 1.55 A particular focus is needed on tackling sepsis, where delay in diagnosis and treatment of can cost lives. There will be new diagnosis and treatment goals for hospitals to help raise standards, and in addition, NHS England will explore the potential to develop an

audit tool which would allow primary care services to audit and improve the consistency of checks made when children have feverish illness and thereby aid the early diagnosis of any children who may have sepsis. Starting with children under five years old, this will eventually extend to adults. In addition to work being undertaken through the Sign Up to Safety initiative, local health services will be supported to improve all aspects of early recognition and effective treatment of sepsis through those local Patient Safety Collaboratives that identify sepsis as a priority, and through workshops, masterclasses and monthly webinars in partnership with the UK Sepsis Trust. This will build on the NHS England Patient Safety Alert issued in September 2014, which promotes the use of a range of resources developed by the UK Sepsis Trust and its partners.

- 1.56 Sir Robert Francis QC was clear in his Public Inquiry report that the principal message of the NHS Constitution should be that patients and their safety come first. In *Hard Truths*, the Department of Health was equally clear in its commitment to ensure that patients and the public are given priority of place in the NHS, and in the NHS Constitution. To this end, the Government has also launched a consultation about refreshing the NHS Constitution, to reflect recommendations made by Sir Robert. These include clear statements on patients' right to an open and transparent relationship with the organisations providing their care; commitments on safe care and avoidable harm; and the importance of a patient-centred NHS.
- 1.57 Finally, there is further work to be done to ensure stronger financial incentives in relation to openness and transparency. *Hard Truths* proposed that, when 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 the claim. This would serve as a further incentive for organisations to develop a culture of candour, transparency and honesty. The Department is publishing a consultation document setting out proposals for how the Duty of Candour could be further incentivised by requiring Trusts and Foundation Trusts to meet a proportion of the cost of negligence claims in cases where they have failed to be candid. It is also committing up to £35 million so that the NHS Litigation Authority can support Trusts in implementing their safety improvement plans where those plans show a likely reduction in higher volume and higher value claims over time.



"We welcome the announcement by the Secretary of State as a major step towards saving lives and reducing the cost of caring for these critically ill patients.

"Sepsis is the hidden killer which claims 31,000 lives in England every year: more than bowel cancer, breast cancer and prostate cancer combined. Rapid access to healthcare, and reliable delivery of the most basic aspects of care, can save an extra 11,000 lives every year."

Dr Ron Daniels, Intensive Care Consultant and Chief Executive of the UK Sepsis Trust

Chapter 2 – Detecting problems quickly

Achievements in the past two years

- The Care Quality Commission is now routinely examining how well organisations handle complaints and those that fall short will have this reflected in their inspection findings.
- The Department of Health and NHS England have issued a new guide for patients on complaining, and a poster setting out how to make a complaint has been made available to the NHS.
- More than five million Friends and Family Test responses have been collected from A&E attendees, inpatients and those using maternity services.
- More than 500 Department of Health staff, as part of the Connecting initiative, have spent over 4,000 days gaining insight from the front line.

Next steps

- The Care Quality Commission's recent *Complaints Matter* report concluded that the quality of complaints handling was variable, and it raised concerns about the timeliness of responses to complaints.
- The Ombudsman has increased the number of cases she deals with, but more needs to be done to restore and maintain public confidence.
- A regular and standardised way of surveying people who have made a complaint in both primary and secondary care is required.
- A review of NHS complaints advocacy services will complete by Spring 2015.

Complaints

- 2.1 One of the more shocking aspects of the events at Mid Staffordshire is the way in which a whole system failed to notice what was happening at the hospital for such an extended period of time. Numb to poor care, there were in places a normalisation and acceptance of standards that were intolerably low and behaviour that was cruel, unsafe and neglectful. The voices of patients and their families went unheard and obvious warning signs of something very wrong were unheeded.
- 2.2 The report on complaints by the Rt Hon Ann Clwyd MP and Professor Tricia Hart called for Trusts to provide patients with clear and simple ways of feeding back comments and concerns about their care on the ward. A template for a poster setting out how to make a complaint was made available to the NHS in November 2014.

- 2.3 The Department of Health and NHS England have also issued an accessible feedback and complaints guide for patients who wish to give feedback or are dissatisfied with the service they have received from the NHS. The guide provides 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. This guide will be published on the NHS Constitution page of the Gov.uk website. In addition, Healthwatch England commissioned Citizens Advice to expand their health and social care section on the Advice guide website to give people up-to-date information and advice on how to navigate the health and social care complaints system.

Handling complaints properly

Figure – Complaints poster for display by providers

[Space to include Trust logo]

Help us to do better

Do you wish to make a complaint about the care, treatment or service provided by our hospital?

You can make a complaint by:

- Speaking to a member of staff
- Writing to the Chief Executive or [eg Complaints Manager]
- Emailing [insert address]

If you can't put your complaint in writing, please contact [insert eg PALS] on [insert phone number] and we will assist you in making your complaint.

[insert local NHS Complaints advocacy provider] can give you free, independent advice and support to make a complaint. You can contact them by [choose telephone or email] on [insert number or email address].

If you remain unhappy with our response to your complaint, you can contact the independent Health Service Ombudsman on 0345 015 4033.





- 2.4 All Care Quality Commission inspections now look into how well providers handle complaints, and this includes examining closed complaints files to see how they were investigated, as well as looking at how Trust boards listen to and learn from complaints. In addition, the Parliamentary and Health Service Ombudsman, together with

Healthwatch England and the Local Government Ombudsman, have published universal expectations for raising concerns and complaints to support improvements in complaint handling. The Parliamentary and Health Service Ombudsman has also published data about the volume of initial enquiries her office receives about individual Trusts along with the details of when complaints against those Trusts are upheld. Improving on the basis of feedback is as important for professionals as for organisations. The Royal College of Nursing has recently published guidance on handling feedback from patients to help front-line nurses and healthcare support workers to understand how to deal with feedback, as well as concerns, complaints and compliments.

Patient feedback

- 2.5 The Friends and Family Test provides near real-time information to drive improvements to service delivery. Since April 2014, it has been used by all providers of NHS-funded acute services for inpatients and in A&E departments, and for all women who use NHS-funded maternity services. More than five million Friends and Family Test responses have been collected from A&E, inpatients and those using maternity services. An NHS England review of the first six months of the Friends and Family Test found that 85 per cent of Trusts are using it to improve patient experience and 78 per cent report that it has increased the emphasis placed on patient experience in their Trusts.

Department of Health Connecting programme

- 2.6 While these measures are giving patients a stronger voice and improving the way in which complaints are handled, if the system is not listening then these measures will be in vain. The Public Inquiry painted a picture of a system of oversight of the NHS which had, at times, become numbed to poor care and overly preoccupied with national targets and financial balance. There was a sense at times of a system that had lost its way, and in places had strayed from its founding values, more concerned to protect the reputation of the system than to protect the patient on the ward.



“We are at a point now where in every aspect of health care, we are asking for user feedback at every juncture and making sure that we try and act on that feedback. We read between the lines and pick up themes.”

Christine Foster, Matron for Maternity, Gynaecology & Sexual Health, Supervisor of Midwives, York Teaching Hospital NHS Foundation Trust



“Connecting has started to shift the culture in the Department. I think people are feeling more energised, more in touch with the impact of their work as a result of it.”

Claire Armstrong, Deputy Director – Compassionate Care Branch, Department of Health

2.7 The Department of Health's ground-breaking Connecting programme has become a trailblazer in Whitehall, with a wide-ranging, back-to-the-floor initiative to help staff to connect with the realities of front-line work in the NHS and the care system. This is to ensure that they are responsive to the experiences of patients and people using services and familiar with the day-to-day pressures on staff. For a generation of civil servants rightly trained to be dispassionate in the advice they give to Ministers, it has been an opportunity to rekindle the values that brought them to work in health and be passionate about their work.

2.8 Following the example of the Secretary of State and the Ministerial team, who have regularly worked shifts in the NHS, within the first year of the programme senior civil servants and policymakers have spent over 4,000 days connecting, 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 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 policymaking. A recent survey of Department of Health staff who had connected revealed that over 85 per cent had a better understanding of the health and care system as a result. And 86 per cent of the health and care partners surveyed believe that the Connecting programme is a good opportunity for civil servants to see what it is really like for patients and those using services.



The Rt Hon Jeremy Hunt MP, Secretary of State for Health, at Newham Hospital

Still to do – next steps on detecting problems quickly

2.9 The work that is under way to listen to patients and service users, and to bring their concerns to centre stage, will be one of the most important forces for improving quality and safety of care. The challenge ahead will be to make listening and responding to patients and staff a natural and highly valued element of the culture of the health and care system everywhere. The key areas for the next phase of reform are:

- **Complaints handling** – in pilots across 11 acute Trusts the Care Quality Commission and the Patients Association found that many hospitals still needed to make it clearer to patients and carers how they could complain and provide better access to patient advice services. And the experience of those complaining still

remained unsatisfactory, with only half of those surveyed feeling that they had received an honest response to their concerns. These findings were mirrored in the Care Quality Commission's recent report *Complaints Matter*, which concluded that the quality of complaints handling was variable and raised concerns over the timeliness of responses to complaints. One way of ensuring that the NHS is getting better at complaints handling is to ask the complainant directly. Many organisations, including NHS England and many acute Trusts, already conduct surveys of complainants on a systematic basis to see how satisfied they were with how their complaint was handled. The Care Quality Commission inpatient survey also tracks whether patients have seen information on how to complain. A working group, chaired by NHS England and supported by key partners, recently explored various options for the introduction of a regular and standardised way of surveying people who have made a complaint in both primary and secondary care. The options have been narrowed down and the most viable are currently being worked up in more detail by the Department of Health, NHS England and other key partners, with the aim of presenting recommendations to Ministers shortly. The Government is encouraged that the Parliamentary and Health Service Ombudsman is listening to feedback about its service and is investigating a much larger number of complaints. These are steps in the right direction, but more needs to be done to restore and maintain public confidence, and it is imperative that the Ombudsman is trusted as an independent adjudicator on complaints which responds promptly, sympathetically and fairly to concerns raised.

- **Advocacy** – The Rt Hon Ann Clwyd MP and Professor Tricia Hart's 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 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. In addition, the Government intends to fund local authorities to provide advocacy services, subject to them making information publicly available to a nationally agreed reporting standard about how that funding is being spent.

Chapter 3 – Taking action promptly and ensuring robust accountability

Achievements in the past two years

- A new, rigorous inspection regime has been introduced for hospitals, GPs and adult social care – and three Chief Inspectors have been appointed. More than half of acute Trusts have already been inspected.
- That process of identifying poor care has been strengthened by setting out the fundamental standards of care which it is unacceptable to breach.
- New legislation to increase the independence of the Care Quality Commission.
- The introduction of Ofsted-style ratings.
- New special measures regime to identify and root out poor care. A total of 19 Trusts have been put into special measures over the past 18 months as a result. Six of these have been turned around and have exited the regime.

Next steps

- More still needs to be done to ensure that those delivering care have clinical accountability and provide patients with a person to guide them through the system.

Inspection and ratings

- 3.1 First, the Care Quality Commission's discredited regime of light touch generalist regulation has been discarded. With a new Chairman, a new Chief Executive and a new board, the organisation has been re-established as an expert independent and robust regulator. The appointment of three new powerful Chief Inspectors, able to point out poor care and demand action without fear or favour, has been key to restoring the credibility and authority of an organisation with the critical responsibility of protecting the interests of patients and service users.
- 3.2 The old light touch model of inspection, in which generalist inspectors with limited expertise made short visits to Trusts, has been transformed. Today, inspections involve leading clinicians and Chief Executives who use their long-standing experience and expertise to probe thoroughly the culture and practice across the complexity of the organisations they visit, talking to patients and listening to staff to get a real feel for what makes the organisation tick. Backed up with a range of data, the teams make judgements about whether care is safe; whether it is responsive; whether it is well led; whether it is effective; and whether it is caring. Where the teams find immediate concerns, they can – and do – call for immediate remedial action.

- 3.3 This new approach to inspection has been tested extensively in the hospital, GP and adult social care sectors, and since 1 October 2014 all inspections in these sectors have been carried out under the new model. The Care Quality Commission will use focused inspections to follow up issues or in response to risk at any time, as required.
- 3.4 The Care Quality Commission inspections now result in a provider rating on a four-point scale of 'outstanding', 'good', 'requires improvement' or 'inadequate' for each of the five domains that it inspects. In addition to an aggregate rating at a provider level, the Care Quality Commission produces ratings for individual services and locations. The Government has recently introduced legislation that requires providers clearly to display their rating.
- 3.5 Sir Robert Francis QC found in his Public Inquiry report that the timetable for making Foundation Trust status universal meant that Mid Staffordshire was given this coveted status without enough attention being paid to the quality and safety of its services. Ratings are now key to making decisions over which Trusts should be given Foundation Trust status, with aspiring Trusts having to achieve a 'good' or 'outstanding' rating under the new inspection regime. Monitor has made it clear that it will not approve Trusts for Foundation status without robust assurance from the Care Quality Commission that applicants are providing a good quality of care for patients.



Professor Sir Mike Richards, Chief Inspector of Hospitals



Professor Steve Field, Chief Inspector of General Practice



Andrea Sutcliffe, Chief Inspector of Adult Social Care

Special measures and enforcement

- 3.6 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 their 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.
- 3.7 The Trust will then be re-inspected by the Care Quality Commission after 12 months to assess progress. Following Professor Sir Bruce Keogh's review of hospitals with high mortality rates, 11 hospitals were put into special measures, and have been provided with extra support from Monitor and the NHS Trust Development Authority.
- 3.8 A further eight Trusts have been placed in special measures after a Care Quality 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 that they improve within no more than 12 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.
- 3.9 Building on lessons from the past 18 months, the Care Quality Commission, Monitor and the NHS Trust Development Authority have signed a new Memorandum of Understanding setting out improvements to the special measures process, and in particular the action that will be taken if any Trust must remain in special measures after the initial 12 months.
- 3.10 Information about the Trusts which have been placed in special measures is set out in the table at the Annex at the end of this document.

Accountability: drawing a line

- 3.11 One of the most important tests of any culture is what it considers acceptable and unacceptable. This is certainly true of the health and social care system. The Public Inquiry highlighted a number of areas where a more robust approach to accountability and related consequences was needed. A new 'fit and proper person' test for directors of NHS bodies has been put in place and in April 2015 will be extended to all providers of health and adult social care registered with the Care Quality Commission. The Government has put in place two new criminal offences of ill-treatment and wilful neglect. One offence will apply to individual care workers providing care as part of their paid work. The other offence will apply to care provider organisations. These new offences will also come into force in April.

3.12 In addition, the Government has put in place a new criminal offence for when care providers make available certain types of information which is false or misleading. 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.

3.13 Clinical professionals are accountable to their regulatory bodies, and those bodies are in turn held to account for their performance by the Professional Standards Authority and the Parliamentary Health Select Committee. In *Hard Truths*, the Government reported that the Nursing and Midwifery Council had committed to introducing an affordable, appropriate and effective model of revalidation for the nursing and midwifery professions to enhance public protection and continue to improve the quality of nursing for patients.

3.14 The intention is to start the introduction of this model at the end of 2015, and 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. It will require every nurse and midwife to revalidate every three years by demonstrating that they have met the requirements of their professional code and standards. As part of revalidation, nurses and midwives will be required to obtain confirmation by a third party of their continuing fitness to practise. This will form a significant part of the process along with feedback from patients, colleagues and peers. The Law Commission's report and draft Bill – intended to simplify and modernise professional regulation law so that the professional regulators are no longer hampered by cumbersome legislation that currently prevents them from investigating complaints and concerns about individuals more promptly – was published in 2014. The Government response was published on 29 January 2015 and legislation will be brought forward when Parliamentary time allows.

“We recognise the value of accurate, reliable information in helping to deliver high quality care. False or misleading information can hinder a care provider’s ability to deliver a quality service or a commissioner or regulator’s ability to monitor it. As such we welcome the new offence as a drive towards ensuring that patients receive the best quality care possible.”

NHS Confederation

Clinical accountability

3.15 The Academy of Medical Royal Colleges has led an important piece of work with the professional community to produce guidance on the role of the responsible clinician. The final guidance was published in June 2014 and describes the purpose of the responsible clinician and named nurse roles with some key considerations for implementation including:

- 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 include a set of key messages to patients that hospitals might wish to use);

- the role of the named nurse, recognising the need for more flexibility because of shift working arrangements; and
- displaying information about accountable clinicians including the importance of patient consent.



3.16 At the same time, the General Medical Council published information which brought together existing guidance in one place to help responsible consultants and clinicians to understand the standards expected of them. Over two thirds of Trusts are

participating in the Name Above the Bed initiative, so that patients, their families and their carers have a named nurse and doctor to provide clinical accountability and continuity of care.

3.17 All registered patients aged 75 and over will have had an accountable GP assigned to them by June 2014. In the case of patients who registered with their GP after 1 April 2014, or registered patients who attained the age of 75 after 1 April 2014, the accountable GP must be assigned within 21 days from the date of their 75th birthday or the date on which they were accepted as a registered patient. From April 2015, this will begin to be extended to all.

Still to do – next steps on action and next steps on accountability

3.18 in the short time since the publication of the Public Inquiry report there has been unprecedented intervention to call a halt to poor care in a significant proportion of NHS hospitals and to make sure that prompt and effective action is taken to restore patient and public confidence and ensure the standards of care that people rightly expect from the NHS. At the same time new mechanisms have been put in place so that individuals can be properly held to account.

3.19 More still needs to be done to ensure that those delivering care have clinical accountability and provide patients with a person to guide them through the system. In the future, 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, but the Government will 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 for ensuring continuity of care for people with complex and multiple needs. As part of this, the Academy 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 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.

- 3.20 A number of the recommendations in Sir Robert Francis QC'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.
- 3.21 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.

Chapter 4 – Ensuring staff are trained and motivated

Achievements in the past two years

- The Care Quality Commission's new inspection regime makes 'well led' one of the five key criteria against which organisations are assessed and inspected.
- Health Education England will work with universities to ensure that the recruitment of applicants to nursing degree programmes will include providing evidence of commitment and suitability to a career in nursing.
- The Care Certificate remains on track to be introduced for new healthcare assistants and social care support workers from 1 April 2015.

Next steps

- There are still significant challenges to building the consistent culture of compassion that values and supports staff and gives everyone in the NHS confidence that they are able to speak up and be heard when they have concerns about care.

Introduction

- 4.1 *Hard Truths* underlined the need to support staff at the front line to deliver the good quality care they want to provide for their patients. This chapter sets out the importance of a culture that values people; what has been done to improve leadership at all levels in the NHS; and measures to ensure that health and care employers recruit the right people with the right values and experience to provide safe, compassionate care. Finally, the chapter details a number of different measures to support staff so that they have the time, resilience and support to deliver compassionate, high-quality care to patients.

Leadership

- 4.2 Good leadership is vital in creating and sustaining a culture in healthcare which understands that, if staff are to treat patients really well, then they themselves need to be really valued by their employers. To broaden the talent available for the top jobs in the NHS, the NHS Leadership Academy has developed and launched this year, in partnership with Harvard University, a new Executive Fast Track programme. It has recruited real high fliers from outside the NHS as well as clinicians who want to take a lead on management. It will significantly increase the number of executive leaders in the NHS from clinical and non-NHS backgrounds.

- 4.3 The NHS Leadership Academy has also introduced professional Leadership Development programmes intended to help strengthen NHS culture by helping leaders to develop the skills, knowledge, values and behaviours needed to improve healthcare and patients' experience of the NHS. Delivered with local and regional partners, the national programmes are the first to combine successful leadership strategies from international healthcare, private sector organisations and academic expertise.
- 4.4 At the same time, Lord Rose of Monewden has been asked by the Secretary of State to consider how best to bolster the leadership cadre available to the NHS. He is considering what more can be done to attract top talent from within and outside the health sector into leading positions in NHS hospital Trusts, and how strong leadership there can be used to transform organisational culture.

The right values and experience

- 4.5 One of the most important lessons of the Public Inquiry was the role that values and experience play in ensuring safe, compassionate care. Nurses, midwives and care staff are in powerful and influential positions to improve the experience of patients, the quality of care and health outcomes across a range of health and care settings. That is why the Compassion in Practice strategy and nursing vision was launched jointly by the Chief Nursing Officer for England and the Director of Nursing in the Department of Health in 2012. It served to lead the delivery of tangible improvements in care through the implementation of clear actions across health and care systems. The influence and reach of the strategy has spanned areas such as helping people to retain their independence, positive experiences for patients and staff, building and strengthening leadership at the front line and delivering high-quality care and measuring impact. It continues to grow at pace and its impact is becoming embedded across many facets of nursing and midwifery care. It is contributing to changing the culture of how care is provided, the ways in which health and care staff work and the outcomes for patients, their families and carers.



“When Robert Francis’ report was published in February 2013, the Academy was on the cusp of launching a series of nursing and midwifery leadership, as well as foundation, mid and senior level professional development programmes. At that time Francis pointed to the need for a leadership college to provide common professional training in management and leadership. Now one year on from the Government’s response, in which it outlined excellent leadership as critical to the delivery of quality care, more than 30,000 staff have signed up to our programmes – from local to regional and national, at all different levels and groups of staff. We know that patients and staff are benefitting as our evidence is already showing that behaviours and cultures are shifting to reflect the care and compassion we all seek in our health service.”

*Jan Sobieraj, Managing Director,
NHS Leadership Academy*

- 4.6 The basis on which people are recruited into caring roles must include an assessment of their values as well as their qualifications. Health and social care employers are now being supported to test for values that are conducive to providing compassionate care when recruiting staff to caring roles. In October 2014, Health Education England published a national values-based recruitment framework. This is an interactive tool including an evidence base, case studies and available resources, to support NHS Employers and higher education institutions in recruiting on the basis of values. Health Education England is also working with providers to support continuing personal development of staff that reinforces these values.
- 4.7 Nursing is a tough job and not everyone has what it takes. Health Education England will promote the use of values-based recruitment to nursing degree programmes, which should include providing evidence of commitment and suitability to a career in nursing. Health Education England has been working with partners across the NHS and higher education to pilot a scheme for aspirant student nurses to spend up to a year on the front line prior to receiving NHS funding for their degree. Some 250 aspirant nurses were recruited in a range of care settings in six areas across England to get real, paid caring experience for up to year as a Healthcare Assistant before they apply to take up an NHS-funded degree course. Evaluation of the pilots shows that the scheme has helped these aspiring student nurses to understand the importance of the need for nurses to have care and compassion as well as the necessary education and skills in order to deliver patient care. Further longitudinal research is under way in order to collect the evidence to support any further conclusions on this important issue.

Care certificate

- 4.8 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 Compassion in Practice programme, which responded to the Francis Inquiry, is producing real and tangible results. It is transforming the way in which health and care staff approach and provide care and supporting our workforce to do the very best that they can. In addition, the underlining principles of our 6Cs continue to gain traction and I am heartened that their influence is being felt beyond professions within the NHS to those operating within the charity and independent sectors. As I look forward I know that Compassion in Practice is also wholly in line with the ‘Five Year Forward View’ in that it places nurses, midwives and care staff right at the core of changes that focus on prevention and wellness.”

Jane Cummings, Chief Nursing Officer, England

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.

Support for staff

- 4.9 One of the most important lessons of the Public Inquiry – reinforced by the groundbreaking study of *Culture and Behaviour in the English NHS* by Mary Dixon-Woods and others – is the close relationship between the wellbeing of staff and outcomes for patients. In part this is about ensuring that the right numbers of staff are in place – and the Government has acted on that issue – but it is also about ensuring that the right support, engagement and values are in place.
- 4.10 In July 2014, the Social Partnership Forum, which brings employers and trades unions together to talk about shared concerns, produced its own guidance, which provides information on effective staff engagement and partnership working, and highlights areas of excellence in NHS organisations where management and trade union representatives have worked together effectively to identify and resolve issues. The recent Review of Staff Engagement and Empowerment in the NHS, led by Chris Ham, sets out a strong case for the correlation between increasing levels of staff engagement and improving quality of care. Following one of the recommendations in the review, Cabinet Office and Department of Health have launched the Mutuals in the Health Pathfinder Programme which explores the role of mutual models in increasing staff engagement within new areas of health. Both of these offer valuable insight into achieving and sustaining the most effective culture.
- 4.11 In addition, NHS organisations have been implementing the Staff Friends and Family Test since April 2014. This is a national approach whereby staff are asked whether or not they would recommend their organisation as a provider of care. The Test provides organisations with regular insight into the views of staff, lets them put forward ideas for improvement, and provides the public with information on staff perception of quality. It is already acting as a catalyst for improvement activity across the NHS. More than 150,000 staff have taken part. According to the Test, 77 per cent of staff would be extremely likely or likely to recommend their organisation to friends and family in need of care or treatment. The NHS Staff Survey shows progress in staff engagement since 2011, with a clear increase in 2013. Some 65 per cent (63 per cent in 2012) of NHS staff said that, if a friend or relative needed treatment, they would be happy with the standard of care provided by their organisation. In addition, 66 per cent (62 per cent in 2012) said that care of patients and service users was their organisation's top priority. The survey also indicated that managers in the system were stronger on the individual support that they offered to team members than, for example, in areas such as seeking feedback and involving staff in decisions.

- 4.12 NHS Employers has continued the ongoing programme of work to support staff engagement in the NHS. This includes providing web-based resources around good practice, disseminating research evidence and providing opportunities to ‘share and learn’ around initiatives such as the Staff Friends and Family Test. NHS Employers is also developing an NHS-specific measure of emotional wellbeing. Individuals and teams will be able to use this measure to consider their own emotional wellbeing and the impact it could have on the delivery of effective, safe and compassionate care.

Still to do – next steps on supporting staff

- 4.13 Delivering safe, effective and compassionate care takes priority for the vast majority of people who work in health and social care. In the NHS indications from the NHS Staff Survey that staff engagement is improving, and the Care Quality Commission’s view that care delivered in the NHS is compassionate is encouraging. But there are still significant challenges in building the consistent culture of compassion that values and supports staff – in particular, to give everyone in the NHS confidence that not only are they able to speak up and be heard when they have concerns about care. We need to ensure that the NHS goes through the same transformation as the airline industry did as it realised that an open culture was critical to ensuring a safe culture.
- 4.14 The General Medical Council has also commissioned Sir Anthony Hooper to undertake a review of how it deals with doctors who raise concerns in the public interest. The review is planned for completion shortly.



“I think the Francis Inquiry represents a line in the sand in relation to how health can be delivered. It feels to me like Francis made it possible for us to say staff experience matters as well as patient experience matters and that you can’t have one without the other. In South London and Maudsley NHS Foundation Trust we are committed to ensuring excellent patient and carer experience.”

Alison Beck, Head of Psychology & Psychotherapy, South London and Maudsley NHS Foundation Trust

Chapter 5 – Conclusion

- 5.1 The events at Mid Staffordshire NHS Foundation Trust were first and foremost a tragedy for the patients and families who suffered unnecessarily because the organisation's leadership had lost its way and created a culture in which some staff would betray their professional values. But the disturbing individual stories of neglect and harm were all the more worrying as they resonated with people's experiences elsewhere in the NHS. The particular story of Mid Staffordshire became emblematic of a widespread concern about a weakening of NHS values so that in parts of the service a defensive culture – concerned more with reputation, money and targets – had overwhelmed the compassionate values that underpin the NHS.
- 5.2 It was important that these hard truths were faced. The programme of action described in this document and the implementation of Sir Robert Francis QC's recommendations described in the accompanying update mark an unprecedented programme to reinvigorate the values of the NHS and to put in place robust safeguards to protect as far as possible against a recurrence of the terrible events at the Trust.
- 5.3 The policy and legislative infrastructure to secure this is now largely in place and the new regime on inspection will roll out across the country over the next two years. What is critical now is that leaders throughout the NHS keep the memory of what occurred fresh in their minds and are inspired by the progress that has been made as new challenges emerge. Good use of resources will always be critical for those who work in healthcare, but it must always be remembered that they are the means to an end – safe, effective, respectful and compassionate care for all our citizens, regardless of their means.



“The last 12 months has seen a very positive response by the NHS to the Francis Report. The realisation that the service needs to be more transparent in its approach to patients and their relatives has been key to laying the foundations to a more caring and safer system. Such measures as the beefing up of Care Quality Commission inspections, the Duty of Candour and the Fit and Proper Person test should ensure that all involved concentrate on the quality of the service they provide. The significant amount of data released as part of My NHS will inevitably through peer pressure improve professional standards. However, regulation is just one part of the solution; there also needs to be a cultural change so that these standards are intuitive and this will require enlightened leadership and for these values to be embedded in education and training for all healthcare workers, be they clinicians or managers. This is the key challenge going forward.”

*Professor Sir Norman Williams,
immediate past President, Royal
College of Surgeons*

Annex – Taking action promptly: Trusts in Special Measures

Trust in special measures	Date placed into special measures	Date exited special measures	Key updates
Basildon and Thurrock University Hospitals NHS Foundation Trust	July 13	June 14	<ul style="list-style-type: none"> The trust was placed in special measures in July 2013 following the Keogh Review, and came out of the regime in June 2014. It now employs an additional 253 nurses and nursing support staff and 14 doctors. Meanwhile its maternity unit was the first in the country to be rated as 'outstanding' when the Care Quality Commission carried out their re-inspection in March 2014. The Care Quality Commission's re-inspection in March 2014 said the change in leadership since the trust was placed in special measures had been significant, with staff saying that they were supported by their peers and managers to deliver good care.
Burton Hospitals NHS Foundation Trust	July 13		<ul style="list-style-type: none"> The trust was placed in special measures in July 2013 following the Keogh Review. It remains in special measures following a Care Quality Commission inspection in April 2014 that assigned the Trust a 'Requires Improvement' rating. The Care Quality Commission found the majority of Keogh actions had been delivered at the time of the inspection but identified a further 12 'must do' actions. The Care Quality Commission identified the trust's enhanced recovery pathways in maternity and orthopaedics as outstanding practice. The trust's improvement director remains in post while it continues in special measures. In response to the reviews by Keogh and Care Quality Commission, the trust has reviewed its nursing workforce numbers in light of national safer staffing guidelines; strengthened its board's focus on quality by appointing two new associate medical directors and a new director of governance; and recruitment of a new substantive medical director is under way. There has been a total increase of 71 nurses and nursing support staff and 18 doctors since June 2013.

Trust in special measures	Date placed into special measures	Date exited special measures	Key updates
Medway NHS Foundation Trust	July 13		<ul style="list-style-type: none"> Key improvement actions in progress include implementing and embedding new divisional governance arrangements; full adoption of the World Health Organisation (WHO) surgical checklist; and ensuring all relevant staff are trained in paediatric life support. The trust is also working with Monitor to identify recovery options in response to its financial deficit position. <hr/> <ul style="list-style-type: none"> Medway NHS Foundation Trust was placed in special measures in July 2013 following the Keogh Review. It remains in special measures, following the April 2014 Care Quality Commission inspection which rated it as 'inadequate'. The trust has employed an additional 108 nurses and nursing support staff and 44 doctors, and is planning to increase the capacity of the emergency department by making available 48 existing beds for emergency assessment and short-stay purposes. Achievements by the trust since the Keogh and Care Quality Commission reviews include delivering significant improvements to maternity services, with Care Quality Commission warning notices removed following the April 2014 inspection; establishing a multidisciplinary team with local partners to support complex hospital discharges; reorganising existing bed space within the hospital to meet winter surges in non-elective activity; and improving decision-making and accountability structures. Key challenges facing the trust are identifying a substantive chief executive officer, which remains a key priority for the trust and for Monitor; failure to meet the quarterly 95% target since Q3 2012/13 and several highly critical external reviews of the emergency department from the Care Quality Commission that resulted in the imposition of a s.31 notice from the Care Quality Commission on 29 August 2014. The Care Quality Commission re-inspected the trust's emergency department in December 2014 and found the trust had implemented initiatives to assess all patients within 15 minutes of arrival and improved compliance with core standards. The Care Quality Commission identified ambulance handovers, delayed transfers of care and working pressures within the emergency department as continuing areas for improvement. The trust continues to deliver a new emergency department estates and performance improvement plan.

Trust in special measures	Date placed into special measures	Date exited special measures	Key updates
North Lincolnshire and Goole NHS Foundation Trust	July 13	June 14	<ul style="list-style-type: none"> • The trust was placed in special measures in July 2013 following the Keogh Review and successfully exited the regime in June 2014. • The trust has employed an additional 186 nurses and nursing support staff since June 2013. • The trust centralised its hyper acute stroke services at Scunthorpe General Hospital last year, which has notably improved patient care. Its maternity services have also been performing well, with the maternity service at Scunthorpe General Hospital winning a national award.
Sherwood Forest Hospitals NHS Foundation Trust	July 13		<ul style="list-style-type: none"> • Sherwood Forest Hospitals NHS Foundation Trust was placed in special measures in July 2013 following the Keogh Review. • It has now employed an additional 160 nurses and nursing support staff and 19 doctors; the complaint backlog has now been addressed; and improvements have been made to quality governance.
Tameside Hospital NHS Foundation Trust	July 13		<ul style="list-style-type: none"> • Tameside Hospital NHS Foundation Trust was placed in special measures in July 2013 following the Keogh Review. • The trust has employed an additional 132 nurses and nursing support staff and 5 doctors since June 2013. • The trust has also commissioned an external review of its governance to make sure its leaders have a better understanding of the trust's key risks and developed a training programme for governors to enable them to hold the trust's leaders to account more effectively. The Care Quality Commission has seen good leadership from the new executive team. • The trust reported in January 2015 that all improvement actions in its special measures action plan are on track for delivery. • A contingency planning team process is currently under way, working with the clinical commissioning group, local authority and other local stakeholders to review local health economy-wide service reconfiguration.

Trust in special measures	Date placed into special measures	Date exited special measures	Key updates
Colchester Hospital University NHS Foundation Trust	Nov 13		<ul style="list-style-type: none"> The trust was placed in special measures in November 2013. In May 2014, the Care Quality Commission re-inspection rated the trust in the 'requires improvement' category. Following inspections of the A&E and EAU (emergency assessment unit) departments in November and December 2014, the Care Quality Commission rated the trust as 'inadequate' for urgent and emergency services and medical care, and the organisation is now rated 'inadequate' overall. The trust has strengthened its leadership team with the substantive appointments of chair, nursing director and finance director and is taking a range of actions to recruit extra nurses. In December 2014 independent reviews highlighted the significant progress the trust has made in addressing cancer concerns raised by the Care Quality Commission. The trust faces significant operational pressure which is affecting its ability to meet targets. Monitor is working with the trust, CQC and wider system to ensure the issues are addressed swiftly.
Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	Oct 13		<ul style="list-style-type: none"> The trust was placed in special measures in October 2013. After a Care Quality Commission re-inspection in July 2014, it is now implementing an amended action plan to address remaining quality issues. The trust has employed an additional 86 nurses and nursing support staff since September 2013, and in the past year has strengthened its leadership with a number of substantive board positions including chair, chief executive officer, medical director, director of nursing and chief operating officer. A contingency planning team process is currently underway working with the CCG to review wide service reconfiguration options. This is due to report in March 2015. The percentage of inpatients who would recommend King's Lynn has risen from 87% to 94% since September 2013.
Buckinghamshire Healthcare NHS Trust	July 13	June 14	<ul style="list-style-type: none"> Buckinghamshire Healthcare NHS Trust was placed in special measures in July 2013 following the Keogh Review and successfully exited the regime in June 2014. The trust has employed an additional 116 nurses and nursing support staff and 4 doctors since June 2013, and was rated 'Good' for 'effective' and 'caring' services when the Care Quality Commission carried out their re-inspection in March 2014.

Trust in special measures	Date placed into special measures	Date exited special measures	Key updates
East Lancashire Hospitals NHS Trust	July 13	July 14	<ul style="list-style-type: none"> Since August 2014 the trust has met the referral to treatment (RTT) non-admitted and incomplete standards, diagnostics standard and all cancer standards and since October the RTT admitted standard has been met – all of which are expected to be sustainable. East Lancashire Hospitals NHS Trust was placed in special measures in July 2013 following the Keogh Review and successfully exited the regime in July 2014. The trust has employed an additional 201 nurses and nursing support staff and 26 doctors since June 2013. In January 2014 The Royal College of Midwives named the Maternity Services ‘Maternity Service of the Year’ for improving normal birth rates, reducing Caesarean section rates and increasing choice for mothers. The trust was rated ‘Good’ for ‘effective’ and ‘caring’ services by the Care Quality Commission during their re-inspection in Spring 2014.
George Eliot Hospital NHS Trust	July 13	July 14	<ul style="list-style-type: none"> George Eliot Hospital NHS Trust was placed in special measures in July 2013 following the Keogh Review and successfully exited the regime in July 2014 with an overall rating of ‘Good’ from the Care Quality Commission. The trust has employed an additional 81 nurses and nursing support staff and 10 doctors since June 2013. The trust’s mortality rates are also now within the expected range. The Care Quality Commission highlighted the Ambulatory Care Unit which opened whilst in special measures as an area of outstanding practice, helping to meet the needs of patients in the community who required medical intervention without the need to be admitted to the hospital. The trust has worked hard to implement seven-day working across the hospital and now benefits from 24/7 senior medical cover in the A&E and acute medical unit.

Trust in special measures	Date placed into special measures	Date exited special measures	Key updates
North Cumbria University Hospitals NHS Trust	July 13		<ul style="list-style-type: none"> • The trust was placed in special measures in July 2013 following the Keogh Review. • Mortality rates within the trust have significantly decreased from being one of the highest in the country, to being within the expected range. • The trust has invested over £1 million into nurse recruitment and development, and has employed an additional 148 nurses and nursing support staff since June 2013. • Following re-inspection in Spring 2014 the Care Quality Commission found that the trust had improved in all areas, but gave it an overall rating of 'Requires Improvement'. Therefore the trust has remained in special measures to allow time to address outstanding issues.
United Lincolnshire Hospitals NHS Trust	July 13		<ul style="list-style-type: none"> • United Lincolnshire Hospitals NHS Trust was placed in special measures in July 2013 following the Keogh Review. • The trust has since invested £4m in recruitment, and there has been an increase of 233 nurses and nursing support staff and 18 doctors since June 2013. Around 1,500 staff have been involved in the improvement of services through the 'Listening into Action' programme. The trust's mortality rates are now within the expected range. • Following re-inspection in Spring 2014 the Care Quality Commission found that the trust had improved in all areas, but gave it an overall rating of 'Requires Improvement'. Therefore the trust has remained in special measures to allow time to address outstanding issues.
Barking, Havering and Redbridge University Hospitals NHS Trust	Dec 13		<ul style="list-style-type: none"> • The trust was placed in special measures in December 2013. It is committed to investing in its staff and safety of patients; for example, the trust has trained 3,000 staff in best practice sepsis care. • The trust has employed an additional 20 nurses and nursing support staff and 10 doctors since November 2013. In addition, the A&E department at Queen's Hospital has been redesigned so that patients are treated in the most appropriate setting with dedicated teams of clinicians to improve care and patient flow. • The trust has made the greatest gains across the London region in improved patient experience – as published by the Care Quality Commission in June 2014.

Trust in special measures	Date placed into special measures	Date exited special measures	Key updates
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	May 14	Oct 14	<ul style="list-style-type: none"> The Trust was acquired by Frimley Park Foundation Trust in October 2014 and is therefore no longer in special measures.
University Hospitals of Morecambe Bay NHS Foundation Trust	June 14		<ul style="list-style-type: none"> The trust was placed in special measures in June 2014. In October 2014, joint trust and commissioner strategic clinical sustainability plans were submitted to NHS England and Monitor to start tackling sustainability issues. In the past year the trust has appointed a new chair and medical director. An interim clinical director for service improvement has also been appointed to support the development of clinical leadership. A full review of clinical staffing has been undertaken and nursing staffing levels have improved. The trust has employed an additional 21 nurses and nursing support staff and 8 doctors since May 2014.
East Kent Hospitals University NHS Foundation Trust	Sept 14		<ul style="list-style-type: none"> The trust was placed in special measures in September 2014. It is currently in the process of confirming the requirements for additional doctors and nurses, with some extra clinical staff now in place. The trust has commissioned reviews covering board quality and governance, data quality and divisional governance, and is implementing recommendations made. It has appointed two external partners to assist with a cultural change programme to address issues identified by the Care Quality Commission around staff engagement. The trust has appointed a substantive chief operating officer and has an interim chief executive officer (CEO), who is due to start in March following the retirement of the current CEO.
Wye Valley NHS Trust	Oct 14		<ul style="list-style-type: none"> Wye Valley NHS Trust was placed in special measures in October 2014. The trust has been buddied with University Hospitals Birmingham NHS Foundation Trust, who have a proven track record of working with a trust in special measures (George Eliot Hospital NHS Trust successfully exited special measures), and are beginning to develop their partnership working. The trust's Improvement Plan has a strong focus on involving staff with the trust – a staff engagement initiative was launched in December 2014 and they are engaging with the Patient and Public Involvement Forum.

Trust in special measures	Date placed into special measures	Date exited special measures	Key updates
Hinchingsbrooke Health Care NHS Trust	Jan 15		<ul style="list-style-type: none"> <li data-bbox="735 488 1394 741">The trust now has a strategic plan for its A&E workforce and has already made progress with the appointment of a Senior A&E Consultant and a new Service Unit Director. The trust is committed to developing its staff and is working with Warwick Medical Leaders Programme to ensure medical staff have the support and skills to achieve improvement in quality. <li data-bbox="735 752 1394 813">The trust was placed in special measures in January 2015. <li data-bbox="735 831 1394 985">Through the special measures regime, the trust will receive a tailored package of support to help it address the issues raised by the Care Quality Commission and improve the quality of care they provide for their patients.

Notes on staff numbers

- Staff figures are obtained from the Health and Social Care Information Centre and cover 16 of 19 special measures trusts, where data is available from one month prior to trusts entering special measures to September 2014. They do not include agency staff.
- Additionally, monthly workforce data can be volatile due to the size of the NHS workforce, it's constantly changing composition, seasonal effects and timing of local data entry and checking processes. There will always remain fluctuation over short periods of time.
- Leadership changes include expected staff turnover as well as some new appointments and may not be attributable to the special measures regime.

ISBN 978-1-4741-1211-6



9 781474 112116