The Thirlwall Inquiry

Review of Implementation of Recommendations from Previous Inquiries into Healthcare Issues prepared by the Thirlwall Inquiry Legal Team

15 May 2024

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1 INTRODUCTION

Question 28 in the Annex to the Thirlwall Inquiry's Terms of Reference asks: "*Whether recommendations to address culture and governance issues made by previous inquiries into the NHS have been implemented into wider NHS practice? To what effect?"*

The Thirlwall Inquiry Legal Team has therefore undertaken a review of the inquiries that have taken place in England & Wales primarily in the last 30 years in order to identify those which relate to events in hospitals and other healthcare settings and/or which relate to the safeguarding of vulnerable individuals.

The tables below prepared by the Inquiry Legal Team focus on the recommendations made by 30 statutory and non-statutory inquiries which are relevant to the issues within the Terms of Reference which the Thirlwall Inquiry is examining.

The recommendations from each inquiry have been set out in the tables below, alongside details of the extent to which each recommendation has been implemented. Evidence of the extent of implementation is based on publicly available information that the Thirlwall Inquiry Legal Team has been able to identify. In addition, comments from Department of Health and Social Care ("**DHSC**") provided in February 2024 have been included in an additional column in the tables from Section 19 (Freedom to Speak Up) onwards.[1]

Where the Thirlwall Inquiry Legal Team has identified evidence that a recommendation has been clearly implemented, the final column has been colour-coded in green. If a recommendation has been rejected, or if there is insufficient evidence of implementation, or if steps have been taken but the implementation is not yet complete, the final column has been left blank.

Each section has a brief introduction to the issues investigated by each inquiry which includes key information and dates. Where possible, links to published reports and other publicly available sources of information have also been included.

The Thirlwall Inquiry Legal Team has categorised and colour-coded certain recommendations which are relevant to four key themes linked to the Terms of Reference. A recommendation which does not fit one of these categories has not been colour-coded, but where a recommendation covers multiple categories, it has been colour-coded as such.

The categories are:

Improving patient safety	**Improving NHS culture and governance**	**Improving the ability to raise complaints and concerns**	**Regulation and oversight of NHS managers**

[1] Except for the Cwm Taf and IICSA inquiries which are outside of DHSC's remit, and the Liverpool Community Health Independent Review and the Independent Medicines and Medical Devices Safety Review which were added to this document after DHSC had provided its comments.

In addition, Appendix 1 features a chronology which sets out on a timeline the date of each inquiry report and the key date(s) when the recommendations made in each report were implemented.

Since the first version of this document was produced in December 2023, four additional inquiries have been reviewed and added to this document in response to feedback from DHSC and Sir Robert Francis.

The tables below will form part of the evidence adduced at the Thirlwall Inquiry oral hearings.

Thirlwall Inquiry Legal Team
15 May 2024

2 REPORT OF THE COMMITTEE OF INQUIRY INTO ALLEGATIONS OF ILL-TREATMENT OF PATIENTS AND OTHER IRREGULARITIES AT THE ELY HOSPITAL, CARDIFF

2.1 Introduction

A Committee of Inquiry constituted in 1967 by the Welsh Hospital Board following allegations of various forms of misconduct on the part of staff at the Ely Hospital, Cardiff. The Report of the Committee of Inquiry was published in March 1969. In light of the fact this Inquiry took place over 50 years ago, a table of its recommendations has not been included in this document. Instead, a brief summary has been provided.
The Committee of Inquiry was tasked with:

- Investigating into allegations made by a former staff member at Ely Hospital concerning ill-treatment of patients and theft by members of staff.
- Examining the situation in the wards at Ely Hospital.
- Making recommendations on the basis of the above.

The Committee of Inquiry found that specific incidents of ill-treatment of patients, including physical assault, had occurred at Ely Hospital. The Committee of Inquiry also found that staff members had consumed significant amounts of food meant for patients. In respect of the culture at Ely Hospital, it found that the atmosphere was one where nursing staff had been persuaded it was useless, if not hazardous, to complain. Some nurses who had complained had been obliged to leave the hospital. Responsibility for this atmosphere was found to lay with senior members of the nursing staff; an inadequate structure of nursing administration which had led to the virtual isolation of the male nursing side; insufficient awareness on the part of the hospital management committee of their responsibility for the quality of nursing care and discipline; and shortcomings in the hospital's complaints system.

In light of its findings, the Committee of Inquiry made a number of recommendations, which included:

- Complete reconstruction of Ely Hospital.
- Recruitment of necessary extra staff.
- Review of the senior nursing structure, so as to reduce isolation of the male nursing side.
- More effective supervision of nursing, with consideration to be given to the strengthening of nursing administration by the appointment of sufficient nursing officers.

- According nursing staff and their representative bodies a higher status in the hospital, and encouraging them to take a more active role in the hospital's affairs.
- Introduction of a system of induction and in-service training for nursing assistants.
- Introduction of an effective system for the proper reporting of incidents and complaints.
- Review of patients' role in the work of the wards.
- Review and overhaul of the hospital management committee's organisation and administration.
- Creation of an independent inspectorate to inspect hospitals like Ely Hospital.
- Consideration be given to the establishment of an independent body which could undertake, in the last resort, consideration of complaints and disciplinary matters which had not been satisfactorily handled in some way.

The findings and recommendations were accepted by the Government.[2]

[2] Ely Hospital, Cardiff: Inquiry Findings, HL Debate 27 March 1969 vol 300 cc1384-93, (Hansard, 27 March 1969) (parliament.uk).

3 THE ALLITT INQUIRY: INDEPENDENT INQUIRY RELATING TO DEATHS AND INJURIES ON THE CHILDREN'S WARD AT GRANTHAM AND KESTEVEN GENERAL HOSPITAL DURING THE PERIOD FEBRUARY TO APRIL 1991

3.1 Introduction

An independent inquiry was commissioned by the Secretary of State for Health to examine the deaths and injuries on the children's ward at Grantham and Kesteven General Hospital during the period February to April 1991, in respect of which nurse Beverley Allitt was convicted of murder, attempted murder and causing grievous bodily harm with intent.

The Inquiry was tasked with:

- Enquiring into the circumstances leading up to the deaths and injuries;
- Considering the speed and appropriateness of the response within Grantham and Kesteven General Hospital to the incidents;
- Examining the appointment procedures and systems of assessment and supervision within Grantham and Kesteven General Hospital and the Mid Trent College of Nursing and Midwifery; and
- Advising on the most efficient ways for health authorities to be informed of and monitor the handling of serious untoward incidents.

The Inquiry emphasised the then unprecedent nature of Beverely Allitt's actions. Nevertheless, the Inquiry identified a number of failures, which included: the background (checks) to the employment of Beverely Allitt as a nurse were unsatisfactory; nursing staff levels of the ward were inadequate; senior management were indecisive when faced with a crisis; consultants on the ward failed to grasp sooner, and act upon, the significance of the series of collapses of children; and efforts to arrange a post-mortem were thwarted.

The Inquiry was chaired by Sir Cecil Clothier QC. The report of the Inquiry was delivered in February 1994, and made 13 recommendations.

3.2 The Allitt Inquiry: Table of Recommendations

The Allitt Inquiry					
Type of Recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
Improving patient safety	**1**	For all those seeking entry to the nursing professions, the most recent employer or place of study should be asked to provide a record of time taken off on grounds of sickness. (February 1994)	In November 1994, the Secretary of State for Health said that, from April 1995, there would be consistent and agreed guidelines on seeking references from the most recent employer or place of study on a record of time taken off on ground of sickness. The Secretary of State said that the English National Board for Nursing, Midwifery and Health Visiting had issued draft regulations and guidelines which would meet this recommendation, and that the University and Colleges Admission Service had agreed to harmonise its recommendations accordingly.	Allitt Report - Hansard - UK Parliament, 2 November 1994.	
Improving patient safety	**2**	In every case Coroners should send copies of postmortem reports to any consultant who has been involved in the patient's care prior to death. (February 1994)	In November 1994, the Secretary of State for Health said that the Home Secretary intended to commend this recommendation in a circular to be issued to all coroners in England and Wales later that month.	Allitt Report - Hansard - UK Parliament, 2 November 1994.	
Improving patient safety	**3**	The provision of paediatric pathology services should be reviewed with a view to ensuring that such services be engaged in every case in which the death of a child is unexpected or clinically unaccountable, whether the post-mortem examination is ordered by a Coroner or in routine hospital practice. (February 1994)	In November 1994, the Secretary of State for Health said that this recommendation had been considered by the Strategic Review of Pathology Services, which had advised more work was required on a number of detailed operational issues. The Secretary of State said a Working Group to look at the issues involved would be set up.	Allitt Report - Hansard - UK Parliament, 2 November 1994.	

The Allitt Inquiry					
			The current position is that a treating clinician is able to request a hospital post-mortem to further investigate a cause of death, but informed consent must be sought.		
Improving patient safety	**4**	No candidate for nursing in whom there is evidence of major personality disorder should be employed in the profession. (February 1994)	In November 1994, the Secretary of State for Health said that guidance on occupational health was to be issued shortly to cover this recommendation. The Secretary of State said that, together with the English National Board's new guidelines, this guidance would establish better procedures for selection of student nurses for training, the selection of staff to work on children's wards and the follow up of staff with a history of excessive absence through sickness.	Allitt Report - Hansard - UK Parliament, 2 November 1994.	
Improving patient safety	**5**	Nurses should undergo formal health screening when they obtain their first posts after qualifying. (February 1994)	In November 1994, the Secretary of State for Health said that guidance on occupational health was to be issued shortly to cover this recommendation. The Secretary of State said that, together with the English National Board's new guidelines, this guidance would establish better procedures for selection of student nurses for training, the selection of staff to work on children's wards and the follow up of staff with a history of excessive absence through sickness. The Nursing and Midwifery Order 2001 (as enacted) provided for the Nursing and Midwifery Council to prescribe the requirements to be met as to the evidence of good health and good character in order satisfy the Registrar that an applicant was capable of safe and effective practice as a nurse.	Allitt Report - Hansard - UK Parliament, 2 November 1994. The Nursing and Midwifery Order 2001 The Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules	

The Allitt Inquiry					
			The Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules Order of Council 2004 (as enacted) required applicants to make declarations as to their good health and character accompanied (for applicants applying for admission to the register on or within 6 months of completion of a pre-registration programme) by a supporting declaration from their education institution. Current Nursing and Midwifery Council Guidance requires student nurses and midwifes to tell their education institution about any health conditions when applying to study to be a nurse, midwife or nursing associate, and which affect their ability to practise safely and effectively.	Order of Council 2004 Health and character as a student - The Nursing and Midwifery Council	
	6	The possibility be reviewed of making available to Occupational Health Departments any records of absence through sickness from any institution which an applicant for a nursing post has attended or been employed by. (February 1994)	In November 1994, the Secretary of State for Health said that guidance on occupational health was to be issued shortly to cover this recommendation. The Secretary of State said that, together with the English National Board's new guidelines, this guidance would establish better procedures for selection of student nurses for training, the selection of staff to work on children's wards and the follow up of staff with a history of excessive absence through sickness.	Allitt Report - Hansard - UK Parliament, 2 November 1994.	
	7	Procedures for management referrals to Occupational Health should make clear the criteria which should trigger such referrals. (February 1994)	In November 1994, the Secretary of State for Health said that guidance on occupational health was to be issued shortly to cover this recommendation. The Secretary of State said that, together with the English National Board's new guidelines, this guidance would establish better procedures for selection of student nurses for training, the	Allitt Report - Hansard - UK Parliament, 2 November 1994.	

The Allitt Inquiry					
			selection of staff to work on children's wards and the follow up of staff with a history of excessive absence through sickness.		
Improving patient safety	**8**	Further consideration be given to not accepting those for training that have shown signs of psychological disorder until they have shown the ability to live an independent life without professional support and been in stable employment for at least to 2 years. (February 1994)	In November 1994, the Secretary of State for Health said that guidance on occupational health was to be issued shortly to cover this recommendation. The Secretary of State said that, together with the English National Board's new guidelines, this guidance would establish better procedures for selection of student nurses for training, the selection of staff to work on children's wards and the follow up of staff with a history of excessive absence through sickness. The Nursing and Midwifery Order 2001 (as enacted) provided for the Nursing and Midwifery Council to prescribe the requirements to be met as to the evidence of good health and good character in order satisfy the Registrar that an applicant was capable of safe and effective practice as a nurse. The Nursing and Midwifery Council (Education, Registration ad Registration Appeals) Rules Order of Council 2004 (as enacted) required applicants to make declarations as to their good health and character accompanied (for applicants applying for admission to the register on or within 6 months of completion of a pre-registration programme) by a supporting declaration from their education institution. Current Nursing and Midwifery Council Guidance requires student nurses and midwifes to tell their education	Allitt Report - Hansard - UK Parliament, 2 November 1994. The Nursing and Midwifery Order 2001 The Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules Order of Council 2004 Health and character as a student - The Nursing and Midwifery Council	

The Allitt Inquiry					
			institution about any health conditions when applying to study to be a nurse, midwife or nursing associate, and which affect their ability to practise safely and effectively. There is no mention of specific requirements for those who have shown sign of psychological disorder.		
Improving patient safety	**9**	Consideration should be given to how GPs might, with the candidate's consent, be asked to certify that there is nothing in the medical history of a candidate for employment in the NHS which would make them unsuitable for their chosen occupation. (February 1994)	The Nursing and Midwifery Order 2001 (as enacted) provided for the Nursing and Midwifery Council to prescribe the requirements to be met as to the evidence of good health and good character in order satisfy the Registrar that an applicant was capable of safe and effective practice as a nurse. The Nursing and Midwifery Council (Education, Registration ad Registration Appeals) Rules Order of Council 2004 (as enacted) required applicants to make declarations as to their good health and character accompanied (for applicants applying for admission to the register on or within 6 months of completion of a pre-registration programme) by a supporting declaration from their education institution. Current Nursing and Midwifery Council Guidance requires student nurses and midwifes to tell their education institution about any health conditions when applying to study to be a nurse, midwife or nursing associate, and which affect their ability to practise safely and effectively. There is no mention of any request for GP certification.	Allitt Report - Hansard - UK Parliament, 2 November 1994. The Nursing and Midwifery Order 2001 The Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules Order of Council 2004 Health and character as a student - The Nursing and Midwifery Council	

The Allitt Inquiry					
Improving patient safety	**10**	The Department of Health should take steps to ensure that its guide "Welfare of Children and Young People in Hospital" is more closely observed. (February 1994)	In November 1994, the Secretary of State for Health referred to efforts by the Government to survey the current staffing arrangements in paediatric nursing, as well as recent growth in the number of nurses entering training for paediatric nursing.	Allitt Report - Hansard - UK Parliament, 2 November 1994.	
Improving patient safety	**11**	In the event of failure of an alarm on monitoring equipment, an untoward incident report should be completed and the equipment serviced before it is used again. (February 1994)	In November 1994, the Secretary of State for Health said this recommendation had been considered by an expert advisory working group which had produced draft proposals which went further than this recommendation.	Allitt Report - Hansard - UK Parliament, 2 November 1994.	
Improving patient safety	**12**	Reports of serious untoward incidents to District and Regional Health Authorities should be made in writing and through a single channel which is known to all involved. (February 1994)	In November 1994, the Secretary of State for Health said the Department of Health would shortly be writing to all regional directors requiring them to establish lines of reporting with chief executives of NHS trusts, so that there could be swift and effective reporting of any untoward incidents.	Allitt Report - Hansard - UK Parliament, 2 November 1994.	
Improving patient safety	**13**	Beverley Allitt's actions should serve to heighten awareness in all those caring for children of the possibility of malevolent intervention as a cause of unexplained clinical events. (February 1994)			

4 THE COMMITTEE OF INQUIRY INTO THE PERSONALITY DISORDER UNIT, ASHWORTH SPECIAL HOSPITAL

4.1 Introduction

A Committee of Inquiry commissioned by the Secretary of State for Health in February 1997 to investigate the functioning of the Personality Disorder Unit at Ashworth Special Hospital following allegations made by a former patient about the misuse of drugs and alcohol, financial irregularities, possible paedophile activity and the availability of pornographic material. The Inquiry was chaired by His Honour Peter Fallon QC. The report of the Inquiry was delivered on 6 January 1999. A link to view the report can be found online.

The Inquiry was tasked with reviewing:

- The policies, clinical care and procedure of the Personality Disorder Unit;
- The security arrangements for the Personality Disorder Unit; and
- The management arrangements at Ashworth Special Hospital for ensuring effective clinical care, appropriate security for patients and the arrangements for visiting.

The Inquiry's remit subsequently expanded to examine Ashworth Special Hospital as a whole and the wider treatment of personality disorder.

The Inquiry found the former patient's allegations largely accurate. Failings the Inquiry identified included: the Personality Disorder Unit was a deeply flawed creation; security was grossly inadequate; medical staff demonstrated incompetence and poor performance; there was a lack of clinical leadership; management was dysfunctional, with a lack of clear operational policies and ill-defined lines of accountability; the relationship with external organisations was overly complex; and previous changes made by Government were ill-thought through.

The Inquiry made 58 recommendations. The Government responded to the report of the Inquiry, and the recommendations it made, in its July 1999 report titled '*The Secretary of State for Health's response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital*'.

4.2 Ashworth Special Hospital Inquiry: Table of Recommendations

Ashworth Special Hospital Inquiry					
Type of Recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
	1	We recommend that the service needs of individuals from minority ethnic groups who suffer from severe personality disorder should be the subject of further study. (6 January 1999)	In its July 1999 response, the Department of Health said that research into the particular needs of minority ethnic groups who suffered from severe personality disorder was a priority for future study and would be considered within an assessment project being carried out between the Department of Health and the Home Office, as well as in the National Programme on Forensic Mental Health Research and Development.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving patient safety	**2**	We recommend that paragraph 25 of the Code of Practice be rewritten to reflect the special circumstances of any high security setting. (6 January 1999)	In its July 1999 response, the Department of Health said that a revised Code of Practice on the Mental Health Act had come into effect from 1 April 1999, making clear that hospital policies on searching could take into account the need for additional security measures to be put in place on account of the dangerous, violent or criminal propensities of the patients cared for in that hospital.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving patient safety	**3**	We recommend that Ashworth Hospital introduces searches of visitors and that paragraph 26 of the Code of Practice be amended to make it crystal clear that in a high security setting visitors who refuse to be searched will not be admitted. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority had introduced a process of searching visitors, with visitors who refused to be search not being admitted to the hospital.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	

Ashworth Special Hospital Inquiry					
	4	We recommend that it is essential to control and monitor the use of ward-based telephones carefully in order to prevent abuse, control fraud and prevent the introduction into the Hospital of prohibited substances and articles. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital had instituted control and monitoring arrangements of ward-based telephones to prevent abuse, with a new patient telecommunications system to become operational at the end of July 1999.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	5	We recommend that policies which allow staff effectively to control and monitor patients' mail are agreed and consistently implemented. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority had agreed a revised Patients' Mail Policy to allow staff to control and monitor patients' mail, with awareness updates now a part of the induction and regular awareness training for staff.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving patient safety	**6**	We recommend: (i) the whole policy of issuing community cards should be reviewed; (ii) the total number issued should never be such as to jeopardise fundamental security requirements; (iii) unless severe personality disordered individuals are physically separated from the mentally ill, those severe personality disordered individuals who hold community cards should not be allowed unescorted access to other parts of the Hospital.	In its July 1999 response, the Department of Health said that the position relating to ground leave for patients in high security hospitals was covered by the Safety and Security in Ashworth, Broadmoor and Rampton Hospitals Directions 1999. The Department rejected the third recommendation, stating that personality disordered patients would continue to be allowed unescorted ground leave within high security hospitals.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	

Ashworth Special Hospital Inquiry					
		(6 January 1999)			
Improving patient safety	**7**	We recommend that an independent review of all aspects of physical security at Ashworth Hospital take place and be repeated at regular intervals. (6 January 1999)	In its July 1999 response, the Department of Health said that an independent review of security at all three special hospitals had been commissioned.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	8	We recommend that patients should not be allowed to use the ward telephone between the hours of midnight and 7am save in the most exceptional circumstances. (6 January 1999)	In its July 1999 response, the Department of Health said that this recommendation had been implemented and the new telephone system would be disabled during these hours.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving patient safety	**9**	We recommend that searching of staff be implemented. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority had accepted this recommendation and plans were in place to implement it, with searching to be in place by August 1999.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving patient safety	**10**	We recommend that, as a matter of urgency, the level of patients' possessions in bedrooms be reduced to, and thereafter maintained at, a level which permits full and thorough room searches to	In its July 1999 response, the Department of Health said that possessions in patients' rooms in the personality disorder unit had been reduced as a matter of urgency and	Response to the Committee of Inquiry into the Personality	

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		be carried out in a reasonable time. (6 January 1999)	a Patients' Possessions Policy agreed to set explicit criteria for possessions and an inventory system for recording.	Disorder Unit, Ashworth Special Hospital, July 1999	
	11	We recommend that no patient should be allowed more than one video cassette recording machine in his bedroom. If any copying or editing of videotapes is required this should be done under supervision within the Education department. (6 January 1999)	In its July 1999 response, the Department of Health said that patients were not permitted more than 1 video machine, which was not to have copying capability, with all video tapes to be checked on entry and recording from television programmes only permitted. Any copying or editing of video tapes was to be undertaken under the supervision of the Education Department.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving patient safety	**12**	We recommend that at all times an up to date book containing all relevant security policies and rules should be easily and readily available to all ward staff, and its location and contents should be known by all ward staff. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Special Authority had ensured a security manual containing all relevant security policies and rules was easily and readily available to all ward staff. Further, a Security Procedures Manual had been issued hospital-wide, its location and contents being known by all ward staff.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving NHS culture and governance	**13**	We recommend the following principles be adopted: (i) there must be clear hospital-wide policies which cannot be changed except at the highest management level; (ii) within the framework of hospital policies there will be a number of clearly defined areas where clinical units/directorates and patient care teams may exercise discretion	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority were incorporating the 7 principles into its storage, retrieval and review of policies and procedures, which was being undertaken by its quality department. Further, Ashworth Hospital would be appointing a project manager for a fixed term with administrative support to ensure full implementation of these recommendations.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	

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		to interpret policies to reflect the distinctive needs of a particular patient group; (iii) where use of such discretion is exercised the fact should be recorded; (iv) any changes to hospital policies should be made known to all staff by an agreed procedure such as regular team briefing. The changes should immediately be added to the Policy File, again before implementation; (v) policies should be clear and easily available to all staff, in a single file. Staff should be required to know the contents of policies. They should attest they have read them and re-attest regarding any changes made to them; (vi) all staff must have read and be aware of policies before they start working on the ward; (vii) the number of policies should be kept to a minimum so that staff are not overwhelmed by paper. (6 January 1999)			

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	14	We recommend that the Ashworth Hospital Senior Management Team is relocated within the secure perimeter of Ashworth North. (6 January 1999)	In its July 1999 response, the Department of Health said that the Director of Safety and Security, the acting Director of Care Services and the 2 Heads of Professions had been relocated to the secure area. However, there was no suitable office accommodation in Ashworth North for all the Senior Management Team without displacing clinical staff. The Ashworth Hospital Authority were said to consider the interim steps already taken sufficient.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving the ability to raise complaints and concerns	**15**	We recommend that the composition and working of the Patients' Council be reviewed to ensure that mentally ill patients are properly represented and that the Council's activities are not dominated by personality disordered patients. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority was committed to ensuring that Council activities were not dominated by personality disordered patients. A development worker was to be appointed to support Patient Council activities, and arrangements would be put in place to ensure the diverse needs of mentally ill patients were reflected.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving NHS culture and governance	**16**	We recommend that minutes of primary care team meetings within the personality disorder unit are routinely sent to and read by the Clinical Director. Relevant remarks should be entered into clinical records where they affect individual patients. (6 January 1999)	In its July 1999 response, the Department of Health said that such minutes were now routinely sent to and read by the Personality Disorder Service Manager, with relevant remarks entered into clinical records.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving the ability to raise complaints and concerns	**17**	We recommend that internal inquiries be conducted by staff who are appropriately trained. Guidance for members of inquiry teams should emphasize that these inquiries are fact-finding. (6 January 1999)	In its July 1999 response, the Department of Health said that the Health Advisory Service 2000 had been commissioned to assist in the development of guidance in investigating serious untoward incidents, specifically in the mental health field and would consider training issues as part of that work. Ashworth Hospital Authority reported that	Response to the Committee of Inquiry into the Personality Disorder Unit,	

Ashworth Special Hospital Inquiry					
			arrangements would be put in place to ensure appropriate training for staff undertaking internal inquiries.	Ashworth Special Hospital, July 1999	
Improving patient safety	**18**	We recommend: (i) Executive Directors and the Director in charge of Security should routinely receive and read serious incident reports; (ii) the relevant clinical team should also receive and read such reports. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority had implemented a revised policy on the reporting of untoward incidents, with Executive Directors, senior managers and members of the relevant clinical team receiving and reading such reports,	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving patient safety	**19**	The Risk Management Team, established in March 1995, would seem the appropriate body to develop its role, and become the intelligence unit of the Hospital drawing on the experience and expertise of the police. We so recommend. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority proposed to establish 5 additional security liaison posts to report to the Head of Security, and to provide security input and a hospital-wide intelligence role.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	20	We recommend that the personality disorder unit, if it is to survive in any form, must be managed separately as a small unit (of around 50 patients maximum), with no more than 8 to 12 patients per ward. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital had identified a range of options to achieve the reduction in ward size, but each had significant capital and revenue costs, as well as staffing issues. Only if sufficient funding and staffing were available could a new structure based on these proposals be implemented.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	21	We recommend that the brief of the Commission for Health Improvement should include the High Security Hospitals and that the Hospitals should be	In its July 1999 response, the Department of Health said that the Health Act 1999 provided for the Commission for Health Improvement to include the special health	Response to the Committee of Inquiry into the	

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		treated as a high priority for attention. (6 January 1999)	authorities providing high security psychiatric services in its rolling programme of independent reviews.	Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving patient safety	**22**	We recommend that Ashworth Hospital should review the control and distribution of prescribed drugs so as to remove the risk of nurses becoming involved in their illegal distribution. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital had conducted such a review. An interim solution had been implemented, which included countersigning drug sheets by specially authorised nurses and highlighting the means by which drugs had been ordered. A detailed plan was also being prepared to improve the stock and distribution control,	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	23	We recommend that no shop should ever be allowed on any personality disorder unit ward unless it is fully controlled by staff and regularly audited by the Finance Department. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority no longer permitted shops on any personality disorder ward.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving NHS culture and governance	**24**	We recommend that the Hospital develops a method for differentiating mandatory policies from guidance. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority would appoint a project manager to ensure there was a method for ensuring the hospital differentiated mandatory policies from guidance.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	

Ashworth Special Hospital Inquiry					
	25	We recommend that no child under the age of 16 should be allowed to visit any patient on a ward. (6 January 1999)	In its July 1999 response, the Department of Health said that directions had been issued under section 17 of the NHS Act 1977 to each of the special hospitals requiring them to ensure that visits by children did not take place on wards or other areas to which patients had general access.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	26	We recommend that a child under the age of 16 should only be permitted to visit a patient who is a genuine member of his or her family, and then only if fully supervised in a place specifically prepared, designed and equipped for visiting purposes. The interests of the child must override those of any other person. (6 January 1999)	In its July 1999 response, the Department of Health said that the guidance accompanying the directions it had issued to each of the special hospitals required for patients who had certain convictions (murder, manslaughter, certain sexual offences, or charged with such an offence but found not guilty by reason of insanity) that visits would only be considered if the patient was a member of the child's family and if in the child's best interests. Otherwise, a child would only be approved to visit a named patient once it had been assessed to be in the child's best interest. Child visits were to be supervised at all times by staff of the appropriate grade.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	27	We recommend that contact with the National Society for the Prevention of Cruelty to Children be revived, and that a training programme on child protection issues be developed in conjunction with the National Society for the Prevention of Cruelty to Children. (6 January 1999)	In its July 1999 response, the Department of Health said that it had been working with the special hospitals in conjunction with the National Society for the Prevention of Cruelty to Children to ensure that each hospital had comprehensive child welfare protection policies and procedures. Ashworth Hospital Authority reported that the National Society for the Prevention of Cruelty to Children were assisting in developing a training plan and delivering training.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	

Ashworth Special Hospital Inquiry					
	28	We recommend that the precise duties and responsibilities of social workers are clarified. (6 January 1999)	In its July 1999 response, the Department of Health said that a review of the role and function of the social work service within special hospitals was underway, to be completed by the end of September 1999.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	29	We recommend that contact with the relevant local authority social services department is always made before a leave of absence trip whenever there is any likelihood of a patient coming into contact with children. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority reported it ensured that contact was always made in circumstances where there was a likelihood of a patient coming into contact with *identified* children, with its Child Protection Interim Procedures Manual reflecting this.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving patient safety	**30**	We recommend an urgent review by the Social Services Inspectorate of the service provided by Social Workers at Ashworth Hospital, using the 1994 Social Services Inspectorate Report as a benchmark. (6 January 1999)	In its July 1999 response, the Department of Health said that a Social Service Inspectorate inspection of Ashworth Hospital had been completed in May 1999, with the Secretary of State for Health accepting the recommendations made which would also inform the Review of Social Work Service to all the special hospitals.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	31	We recommend: (i) that on the personality disorder unit full room searches should be carried out on a regular basis by dedicated and trained teams;	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority had implemented regular searches by ward staff to agreed standards and subject to audit, with dedicated search teams available on demand. Search results were said to be cross-checked against a manual up to date inventory.	Response to the Committee of Inquiry into the Personality Disorder Unit,	

Ashworth Special Hospital Inquiry					
		(ii) the search results should be cross-checked against patients' up to date property lists. (6 January 1999)		Ashworth Special Hospital, July 1999	
	32	We recommend: (i) searches and checks of documentation on leave of absence trips should be carried out by the gate security staff, and complete records be kept of such searches; (ii) escorting staff should also be searched on leaving and returning from leave of absence trips. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority had ensured patients going on leave of absence rehabilitation visits were searched at ward level and on exit and entry to the site in the presence of the Site Manager, who also checked documentation and kept complete records. However, it was said to be impractical for gate security staff to carry this out. The second part of the recommendation was to be implemented on introduction of staff searching.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	33	We recommend that patients should only be allowed adapted computers connected to a patients' server in their rooms. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority did not permit patients to have personal computers at all and therefore there were no computers in patient rooms.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	34	We recommend: (a) no modems whether external or internal should be permitted in ward areas;	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority reported implementing these recommendations save that remote diagnostic	Response to the Committee of Inquiry into the Personality Disorder Unit,	

Ashworth Special Hospital Inquiry					
		(b) patients' access to telephones should be limited to: (i) telephone numbers on the list of the patient's list of approved numbers; (ii) all telephone calls by patients should be carefully monitored, except privileged calls, such as those to legal advisers, in which cases the number should be dialled by a member of staff who, having done so, should retire out of ear-shot, but maintain observation to ensure no other number is dialled; (iii) telephone points in ward visitors' rooms should be removed; (iv) permitting external telephone engineers to control the Hospital's telephone exchange should be reconsidered. (6 January 1999)	arrangements were still in place for the telephone exchange.	Ashworth Special Hospital, July 1999	
	35	We recommend that patients are not allowed to have in the Hospital: mobile telephones; personal organizers; palm top computers; hand-helds; laptop computers; and pagers. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority did not permit patients to have any of these devices in Ashworth Hospital.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	36	We recommend that before patients are allowed to have personal computer printers, it is demonstrated that the parallel port to which such a printer must be connected could not also be used for unacceptable devices. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority did not permit patients to have personal computers or printers, with the only computers to which patients had access being closely supervised by staff.	Response to the Committee of Inquiry into the Personality Disorder Unit,	

Ashworth Special Hospital Inquiry					
				Ashworth Special Hospital, July 1999	
Improving NHS culture and governance	**37**	We recommend that the position of Responsible Medical Officer should be an accredited post which is reviewed at no more than five-yearly intervals. (6 January 1999)	In its July 1999 response, the Department of Health referred to the plans for the General Medical Council to introduce a process of revalidation which all medical practitioners would be subject to. In light of these, the Department said it did not intend to develop separate proposals for Responsible Medical Officers, who would be medical practitioners subject to such revalidation. In fact, revalidation requirements for doctors were not introduced by the General Medical Council until December 2012.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999 Revalidation - Current State of Play. Revalidation Process. | Patient	
Improving NHS culture and governance	**38**	We recommend that the new policies relating to clinical governance spell out as clearly as possible the powers and authority of a Medical Director in such a way as to strengthen the role in an acceptable manner. (6 January 1999)	In its July 1999 response, the Department of Health said that it had issued guidance setting out clear expectations for the implementation of clinical governance, and emphasising the importance placed on senior level commitment to its application. The Department said that the development and support needs of local medical directors would be addressed through work to develop and sustain effective senior leadership in local health services.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	39	We recommend the development of training for nurses in the treatment and management of personality disorder with appropriate certification. (6 January 1999)	In its July 1999 response, the Department of Health said that it would seek advice on these matters from the relevant professional bodies. Ashworth Hospital Authority reported a training programme had been developed for nurses in the	Response to the Committee of Inquiry into the Personality Disorder Unit,	

Ashworth Special Hospital Inquiry					
			treatment and management of personality disorder, to commence in September 1999.	Ashworth Special Hospital, July 1999	
Improving patient safety	**40**	We recommend that a thorough review takes place of night staffing at Ashworth Hospital. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority had commenced a review of night staffing and that the review would form part of the local action within the National Workforce Review.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	41	We recommend that as far as possible bank staff be allocated to particular areas of the Hospital, and that induction for bank staff opting to work within the personality disorder unit includes some additional instruction on working with personality disordered patients. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority had commenced a review of bank arrangements, which included allocation policies, induction training and training for bank staff working with personality disordered patients. In the interim, increased efforts were being made to provide consistency in allocating bank staff to services.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	42	We recommend that input of clinical psychology to the personality disorder unit should be sharply increased. (6 January 1999)	In its July 1999 response, the Department of Health said that Ashworth Hospital Authority had undertaken a review of clinical psychology input into the personality disorder unit, which indicated a minimum increase in the number of psychologists needed. This was to be on the hospital's agenda for discussion as part of the Service and Financial Framework for 1999/2000.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	

Ashworth Special Hospital Inquiry					
	43	We recommend the High Security Psychiatric Services Commissioning Board funds work in the area of social therapy. (6 January 1999)	In its July 1999 response, the Department of Health said that the High Security Psychiatric Services Commissioning Board had invested £88,000 in this area of work over the last 3 years and were seeking funds from the European Commission to develop this aspect.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
Improving NHS culture and governance	**44**	We recommend that Ministers reflect on our comments and consider whether the chains of accountability in the NHS, at all levels, should be reviewed and clarified. (6 January 1999)	In its July 1999 response, the Department of Health said that it had established a clear chain of communication between the Chief Executive of the Hospital Authority, the Regional Director of the NHS Executive North West Regional Office and the Chief Executive of the NHS Executive. The Department further referred to the Health Act 1999 as putting in place stronger accountability arrangements covering the whole of the NHS, as well as clinical governance arrangements meaning the Boards of NHS organisations would be held accountable for the quality of treatment and care. The Department also said that the objective and arrangements for commissioning services had been clarified through the introduction of the National Service Framework, Health Improvement Programmes and the commissioning of special services.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	45	The numbers [of severely personality disordered offenders], as Professor Gunn described them, are a rough estimate. We recommend: (i) that 300 places in hospital and 100 places in prison be provided for this severely	In its July 1999 response, the Department of Health said that it would expand and develop specialist provision in the context of the wider development of policy for the management of people with severe personality disorder in secure environments. The Department said an expert group had been established to advise on the development of a systematic approach to the assessment of dangerous	Response to the Committee of Inquiry into the Personality Disorder Unit,	

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		personality disordered group as soon as possible; (ii) that before any longer-term investment is made the Government sets up an expert group with resources to commission research so as to establish a sound base for future service development. (6 January 1999)	severely personality disordered people which would help establish a basis for decisions on future investment in specialist services.	Ashworth Special Hospital, July 1999	
Improving NHS culture and governance	**46**	We recommend that all purchasing for forensic services is managed on a region-wide basis. (6 January 1999)	In its July 1999 response, the Department of Health said that from April 2000 commissioning of high and medium secure psychiatric services would be undertaken by regional specialised commissioning sub-groups, which would be expected to work closely with health authorities and service providers to plan and commission integrated forensic psychiatric services.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	47	We recommend: (i) the establishment of regional networks of forensic services embracing all levels of security from high security to the community; (ii) the transfer of high security facilities to regional networks; (iii) the urgent provision of more medium secure and long-term medium secure	In its July 1999 response, the Department of Health said that provisions in the Health Act 1999 enabled high security psychiatric services to be managed by NHS trusts. In preparation for closer integration, the 3 special hospital authorities were working with other providers of mental health services in their local areas. The Department referred to 'Modernising Mental Health Services' as setting out the requirement for integrated mental health services, with funding to be invested in additional provision of secure places.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	

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		accommodation within the regional networks; (iv) the development of increased functional integration between prison services for persons with severe personality disorder and the regional forensic services; (v) the continuing care of those with severe personality disorder should always be provided by a multi-disciplinary team with a detailed knowledge of the individual. (6 January 1999)	As to the fifth part of the recommendation, the Department said such issues would be taken into account in a project set up to advise the Department of Health and the Home Office on future organisational arrangements for dangerous people with severe personality disorder.		
	48	We recommend that the NHS takes over responsibility for healthcare within prisons. (6 January 1999)	The Government rejected this recommendation. In its July 1999 response, the Department of Health said that there would instead be closer working between the Prison Service and the NHS at all levels, with the establishment of a Prison Health Care Task Force to work with prisons and local health organisations and support them in establishing joint working arrangements.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	49	We recommend that Ashworth Hospital should close in its entirety at the earliest opportunity. (6 January 1999)	The Government rejected this recommendation. In its July 1999 response, the Department of Health said that closure of Ashworth Hospital would conflict with the Government's objective to secure the safety of the public and improve services for mentally ill patients who need care in high security.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	

Ashworth Special Hospital Inquiry					
	50	We recommend the creation of: (i) a new sentence called a "Reviewable Sentence"; (ii) a "Reviewable Sentence Board". (6 January 1999)	In its July 1999 response, the Department of Health said that a consultation paper had been issued setting out policy proposals for managing dangerous people with severe personality disorder. In the Criminal Justice Act 2003, the Government created sentences of imprisonment for indeterminate periods for dangerous offenders.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999 Criminal Justice Act 2003	
	51	We recommend: (i) removing "psychopathic disorder" from the Mental Health Act 1983; (ii) replacing it with "personality disorder", save in the specific instances set out below; and (iii) not defining "personality disorder" in the Act. (See Appendix 9 for all suggested amendments to the 1983 Act.) (6 January 1999)	In its July 1999 response, the Department of Health said that it had drawn this recommendation to the attention of the independent Scoping Group advising the Secretary of State for Health on the review of the Mental Health Act 1983. The Mental Health Act 2007 removed 'psychopathic disorder' from the Mental Health Act 1983, along with the other defined 'disorder' and 'impairment' terms, substituting them all with "*'mental disorder'*" defined as *"any disorder or disability of the mind*".	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999 Mental Health Act 2007.	
	52	We recommend that those currently undertaking the review of the Mental Health Act should be asked to consider the definitions of severe mental impairment and mental impairment in the light of our recommendations. (6 January 1999)	In its July 1999 response, the Department of Health said that it had drawn this recommendation to the attention of the independent Scoping Group advising the Secretary of State for Health on the review of the Mental Health Act 1983.	Response to the Committee of Inquiry into the Personality Disorder Unit,	

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			The Mental Health Act 2007 removed 'psychopathic disorder' from the Mental Health Act 1983, along with the other defined 'disorder' and 'impairment' terms, substituting them all with "*'mental disorder"'* defined as *"any disorder or disability of the mind*".	Ashworth Special Hospital, July 1999 Mental Health Act 1983. Mental Health Act 2007.	
	53	We recommend: (i) abolishing hospital orders (with or without restriction), and of the present form of transfer orders, for individuals suffering from personality disorder by not replacing "psychopathic disorder" with "personality disorder" in sections 37(2) (a)(i) and 47(1)(a) and (b) of the 1983 Act; (ii) that a new transfer direction be enacted to facilitate such transfers on those bases. This would facilitate transfer of personality disordered offenders when appropriate, and also their transfer back under section 50 of the Act if appropriate. (6 January 1999)	In its July 1999 response, the Department of Health said that it had drawn this recommendation to the attention of the independent Scoping Group advising the Secretary of State for Health on the review of the Mental Health Act 1983. The Mental Health Act 1983, as amended by the Mental Health Act 2007, makes no explicit distinction between those suffering from personality disorder and those suffering from other mental disorders for the purposes of hospital orders.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999 Mental Health Act 1983. Mental Health Act 2007.	
	54	We recommend that section 38 (1)(a) be amended by removing "psychopathic disorder", and that a provision for an interim transfer direction for assessment for up to 12 months be enacted to	In its July 1999 response, the Department of Health said that it had drawn this recommendation to the attention of the independent Scoping Group advising the Secretary of	Response to the Committee of Inquiry into the Personality	

Ashworth Special Hospital Inquiry					
		provide such transfers for personality disordered offenders from prison. (6 January 1999)	State for Health on the review of the Mental Health Act 1983. The Mental Health Act 1983, as amended by the Mental Health Act 2007, makes no explicit distinction between those suffering from personality disorder and those suffering from other mental disorders for the purposes of section 38.	Disorder Unit, Ashworth Special Hospital, July 1999 Mental Health Act 1983. Mental Health Act 2007.	
	55	We recommend: (i) that "personality disorder" should replace "psychopathic disorder" in Part II of the Mental Health Act 1983 and the deletion of "psychopathic disorder" altogether from section 3(2)(b); (ii) for minor offenders we recommend further development of the Court Diversion scheme to facilitate admission and treatment under Part II of the Act. (6 January 1999)	In its July 1999 response, the Department of Health said that it had drawn this recommendation to the attention of the independent Scoping Group advising the Secretary of State for Health on the review of the Mental Health Act 1983. The Mental Health Act 2007 removed 'psychopathic disorder' from the Mental Health Act 1983, along with the other defined 'disorder' and 'impairment' terms, substituting them all with "*'mental disorder'*.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999 Mental Health Act 1983. Mental Health Act 2007.	
	56	We recommend that all Clinical Management Assessments are carried out in separate assessment facilities. (6 January 1999)	In its July 1999 response, the Department of Health said that an expert group had been established to advise the Department of Health and the Home Office on the development of a systematic approach to the assessment of dangerous people with severe personality disorder. This	Response to the Committee of Inquiry into the Personality Disorder Unit,	

Ashworth Special Hospital Inquiry					
			would involve looking at the viability of establishing specialist assessment facilities.	Ashworth Special Hospital, July 1999	
	57	We recommend that the Department of Health and the Home Office convene a working group to develop a standardised assessment protocol for severe personality disorder, involving all the appropriate representative bodies. (6 January 1999)	In its July 1999 response, the Department of Health said that an expert group had been established to advise the Department of Health and the Home Office on the development of a systematic approach to the assessment of dangerous people with severe personality disorder. This would involve the development of a standardised assessment protocol.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	
	58	We recommend that the Department of Health and the Home Office develop special units for severely personality disordered offenders, housing no more than 50 men, in sub-units of 8 to 12. (6 January 1999)	In its July 1999 response, the Department of Health said that the Government agreed that services for people with severe personality disorder in secure environments should be organised in a way that ensured places within each management unit were limited to a viable number. The Department said that officials from the NHS Executive, Home Office and Prison Service were working with clinicians and managers from the 3 high security hospitals to identify and promote good practice in this area.	Response to the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, July 1999	

5 ROYAL LIVERPOOL CHILDREN'S HOSPITAL INQUIRY

5.1 Introduction

A public inquiry set up in December 1999 to investigate the removal, retention and disposal of human organs and tissues following post-mortem examination at the Royal Liverpool Children's Hospital. The Inquiry was chaired by Michael Redfern QC. The report of the Inquiry was delivered in January 2001. The report can be viewed online here.

The Inquiry was tasked with:

- Inquiring into the circumstances leading to the removal, retention and disposal of human tissue, including organs and body parts, from children at the Royal Liverpool Children's NHS Trust who had undergone post mortem;
- Inquiring into the extent to which the Human Tissue Act 1961 has been complied with;
- Examining professional practice and management action and systems, including what information, and in what form, was given to the children's parents, or where relevant, other family members, in respect of the removal, retention and disposal of tissue; and
- Examining the role of the NHS and other persons or bodies involved.

The Inquiry found that: hearts were collected at Alder Hey Hospital without parental knowledge or lack of objection being established; there was abundant evidence of failure on the part of clinicians to make the requisite enquiries of parents to see if they objected to a deceased's child's body being used for treatment, medical education or research purposes; clinicians were uncertain as to what deaths should be reported to the Coroner; and there were serious management failings on the part of Alder Hey Hospital and the University of Liverpool.

The Inquiry made 67 recommendations.

5.2 Royal Liverpool Children's Hospital Inquiry: Table of Recommendations

Royal Liverpool Children's Hospital Inquiry					
Type of Recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
Handling of the organ retention issue					
Improving patient safety	**1**	Serious Incident Procedures should be developed and put in place. (January 2001)	Implementation unknown.		
Improving patient safety	**2**	In the event of a serious incident the Chief Executive and Trust Board shall devise a suitable Serious Incident Procedure similar to those already in place for major disasters and review it from time to time making any necessary alterations. (January 2001)	Implementation unknown.		
Improving patient safety	**3**	When the procedure has been devised and prior to implementation the NHS Executive Regional Office shall assess its suitability and thereafter manage its performance, devising and instigating any necessary alterations from time to time. (January 2001)	Implementation unknown.		
Improving NHS culture and governance	**4**	In devising a Serious Incident Procedure the Chief Executive and Trust Board shall consider the need for a serious incident team independent of the hospital. (January 2001)	Implementation unknown.		

Royal Liverpool Children's Hospital Inquiry					
Improving patient safety	**5**	In devising a Serious Incident Procedure the Chief Executive and Trust Board shall consider the need for urgent professional counselling: • A proportion of individuals within any group is always likely to require psychological support in the aftermath of disaster. • An individual within the serious incident team shall be nominated to take responsibility for the arrangements and the identification of all those in need. • Suitably trained practitioners shall provide the counselling. (January 2001)	Implementation unknown.		
Improving patient safety	**6**	In devising a Serious Incident Procedure the Chief Executive and Trust Board shall take advice from and where necessary include within the serious incident team appropriate experts in bereavement, pathological reactions to bereavement and therapy. (January 2001)	Implementation unknown.		
Improving patient safety	**7**	The Chief Executive and Trust Board shall make available suitably trained staff for implementing the Serious Incident Procedure. (January 2001)	Implementation unknown.		
	8	The Chief Executive and Trust Board shall inform all staff when a Serious Incident Procedure is in force. (January 2001)	Implementation unknown.		

Royal Liverpool Children's Hospital Inquiry					
	9	The Chief Executive and Trust Board shall ensure the proper debriefing and support of all staff associated with a serious incident. (January 2001)	Implementation unknown.		
	10	Universities and other public bodies shall adopt compatible procedures when acting in conjunction with an NHS serious incident. (January 2001)	Implementation unknown.		
	11	Records should be reviewed and updated and an audit trail should be developed and put in place. (January 2001)	Implementation unknown.		
	12	The Chief Executive and the Trust Board shall review and update medical and pathology records to include, preferably on computer and cross-referenced, the following information: • name, medical record reference number and date of birth; • date, place of death and death certificate; • name and address of next of kin; • whether Coroner's or hospital post mortem examination; • date of consent for hospital post mortem examination; • names of pathologist and those in attendance; • post mortem examination reference number; • date of examination; • date of preliminary/final post mortem reports; • date histology completed;	Implementation unknown.		

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		• record of specific instructions from the Coroner or clinicians; • record of retained organs, samples, wax blocks, slides, photographs, X-rays, date and method of dispersal or disposal; • case notes; • signed consent form; • copy of any other relevant correspondence or notes; • name and address of general practitioner; • date post mortem report sent to general practitioner; • record of communication of findings to the next of kin. (January 2001)			
	13	University records shall provide a confidential audit trail back to the clinical record. (January 2001)	Implementation unknown.		
	14	University records shall identify receipt, use, dispersal and ultimate disposal of any organ or sample. (January 2001)	The Human Tissue Authority published its Code of Practice for post-mortem examinations in July 2006, which provided that establishments should ensure that systems are in place to maintain proper records and documentation for all tissue and organs they acquire and/or pass on to others. The Designated Individual named in licences issued by the Human Tissue Authority must ensure that such systems are in place.	Code of Practice - Post mortem examination, Human Tissue Authority, July 2006	
Relationship between Universities and Trusts					

Royal Liverpool Children's Hospital Inquiry					
Improving NHS culture and governance	**15**	Whatever the underlying contractual position, the relationship between Universities and Trusts, in respect of individuals and departments with dual clinical and academic functions, shall be one of the utmost good faith in both directions. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The Follett Report did not address this recommendation.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties - Follet Review (2001)	
Improving NHS culture and governance	**16**	The duty of utmost good faith shall require either party to disclose to the other any substantial matter relating to the performance of the individual or department, whether clinical or academic. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The Follett Report did not address this recommendation.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties - Follet Review (2001)	
Improving NHS culture and governance	**17**	Where there is any doubt as to whether a matter is of a substantial nature, if it relates to patient care the doubt shall always be resolved in favour of disclosure. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The Follett Report did not address this recommendation.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with	

Royal Liverpool Children's Hospital Inquiry

				Academic and Clinical Duties - Follet Review (2001)	
Improving NHS culture and governance	**18**	The appointment of clinical academics shall be approached with fair representation on each side reflecting the proposed split between clinical and academic sessions. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The foreword stated the Department was looking for real and positive progress towards full implementation of its recommendations by the end of the year. The Follett Report recommended that appointments to senior NHS and university staff posts with academic and clinical duties should be jointly made under procedures agreed by the partners, with a job description formally approved in advance by NHS bodies and by the university, to ensure proper balance is maintained between all the components of the role.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties - Follet Review (2001)	
Improving NHS culture and governance	**19**	The appointment of external advisors shall be approached on the basis that they are truly external, if not strictly independent in a legal sense. There is no point having external advisers as 'window dressing' for a fixed internal view. Where they or representatives of the Royal Colleges give advice, proper weight shall be given to that advice. In giving advice, external advisers shall bear in mind the paramount requirement of patient care where there is a conflict of interest. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The Follett Report did not address this recommendation.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties -	

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				Follet Review (2001).	
Improving NHS culture and governance	**20**	A single job description for clinical academics shall be drawn up jointly to represent a fair and realistic expectation of the work envisaged by both parties. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The foreword stated the Department was looking for real and positive progress towards full implementation of its recommendations by the end of the year. The Follett Report said that job descriptions of new and replacement senior NHS and university staff posts with academic and clinical duties should be jointly prepared and formally agreed by both partners prior to advertisement. The material about the post made available to candidates who responded to advertisements or searches was to include the full job description.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties - Follet Review (2001)	
Improving NHS culture and governance	**21**	There shall be a joint procedure for disciplinary action against an individual perceived to be failing. It shall contain provision for immediate suspension from patient care as a minimum, irrespective of academic requirements and positions. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The foreword stated the Department was looking for real and positive progress towards full implementation of its recommendations by the end of the year. The Follett Report stated that associated universities and NHS bodies should jointly prepare a formal agreement on the procedure for the management of poor performance and for discipline to be followed for senior NHS and university staff members with academic and clinical duties. These procedures were to ensure joint working in the	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties - Follet Review (2001)	

Royal Liverpool Children's Hospital Inquiry					
			process, specify which body was to take the lead in the different types of cases, ensure suitable cross membership of disciplinary bodies and be expeditious.		
Improving NHS culture and governance	**22**	There shall be formal annual appraisal of an individual by both parties. They shall share their information in line with the duty of utmost good faith in order to draw up a joint statement of aims in the following 12 months against which the next appraisal is to be judged. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The foreword stated the Department was looking for real and positive progress towards full implementation of its recommendations by the end of the year. The Follett Report stated that associated universities and NHS bodies should work together to develop a jointly agreed annual appraisal and performance review process based on that for NHS consultants, to meet the needs of both partners.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties - Follet Review (2001)	
Improving patient safety	**23**	Where there is disagreement each party shall reconsider bearing in mind that patient care is of paramount importance. In the event of continued disagreement an arbitrator may be appointed, but in any case the Trust shall take immediate steps to secure proper patient care. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The Follett Report did not address this recommendation.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties -	

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				Follet Review (2001)	
	24	The relationship between Universities and funding bodies shall be of the utmost good faith and similar considerations shall apply.	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The Follett Report did not address this recommendation.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties - Follet Review (2001)	
New Ventures					
Improving patient safety	**25**	Where a new venture, such as the establishment of a Chair or department, is contemplated, both parties where appropriate shall consider in detail the aims and resources available and draw up a realistic business plan before any final commitment is made. As in all these matters, if patient care is to be included in the venture, patient care shall be paramount in its consideration. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The Follett Report did not address this recommendation.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties - Follet Review (2001)	

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Improving NHS culture and governance	**26**	There shall be close performance management of any new venture in its early stages and appropriate steps taken to modify the business plan as required. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The Follett Report did not address this recommendation.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties - Follet Review (2001)	
	27	Any substantial alteration in an existing venture shall be treated as if a new venture. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The Follett Report did not address this recommendation.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties - Follet Review (2001)	
Audit					
Improving NHS culture and governance	**28**	Where there is good reason to believe that an individual or department may be failing and affecting patient care, it shall be the duty of the Trust with the co-operation of the university, and if appropriate on a joint basis, to investigate.	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The Follett Report did not address this recommendation.	A Review of Appraisal, Disciplinary and Reporting Arrangements for	

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		Investigation shall continue until the problems are identified or it is found that in reality no problem exists. Where appropriate, independent outside assistance shall be obtained. (January 2001)		Senior NHS and University Staff with Academic and Clinical Duties - Follet Review (2001)	
Improving NHS culture and governance	**29**	Where problems are identified a plan, jointly where necessary, shall be drawn up to resolve them as soon as possible. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The Follett Report did not address this recommendation.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties - Follet Review (2001)	
Improving NHS culture and governance	**30**	If no solution is found after all diligent attempts, the parties should keep records of their attempts and the reasons why they have failed, such records to be lodged by way of report to the relevant NHS Executive Regional Office. (January 2001)	In September 2001, the Follett Report reviewing arrangements for staff with academic and clinical duties was published by the Department for Education and Skills. The Follett Report did not address this recommendation.	A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties - Follet Review (2001)	

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Management standards					
Improving NHS culture and governance **Regulation and oversight of NHS managers**	**31**	No clinician shall be appointed to a position of managerial authority in a hospital without having relevant clinical experience for the position. (January 2001)	Implementation unknown.		
Improving NHS culture and governance **Regulation and oversight of NHS managers**	**32**	No clinician should take effective control of a management position until trained in all necessary management techniques and in any relevant legal requirements. (January 2001)	Similar recommendations were addressed by the Department of Health in its January 2002 response to the recommendations of the Bristol Royal Infirmary Inquiry (recommendations 93 and 94). In its response, the Department of Health said it agreed with the recommendations. The Department referred to clinical director and medical director development programmes to be rolled out from January 2002, as well as the development of the NHS Leadership Qualities Framework, which it said would be applied to clinicians moving into managerial roles.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance **Regulation and oversight of NHS managers**	**33**	No clinician shall be asked to take on responsibilities that impair the ability to carry out patient care to the appropriate standard. (January 2001)	Implementation unknown.		

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Improving NHS culture and governance **Regulation and oversight of NHS managers**	**34**	Hospital managers shall be of a suitable background and calibre for the role expected of them, provided with all necessary training (including continued education) and themselves regularly appraised for the quality of their performance. (January 2001)	Similar recommendations were addressed by the Department of Health in its January 2002 response to the recommendations of the Bristol Royal Infirmary Inquiry in relation to directors (recommendations 50 and 54). In its response, the Department of Health said an induction guide for chairs and non-executive directors was being developed by the NHS Leadership Centre and the NHS Appointments Commission, to be published in January 2002. In response to recommendation 64, the Department said it would ensure that managers and clinicians had more opportunities to learn about their respective roles and work pressure through the Lifelong Learning Programme.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance **Regulation and oversight of NHS managers**	**35**	Hospital managers without medical qualification shall seek medical advice on matters requiring it. If there is doubt as to the need for advice on any matter relating to patient care, the doubt shall be resolved by seeking advice. (January 2001)	Implementation unknown.		
Improving NHS culture and governance **Regulation and oversight of NHS managers**	**36**	While hospital managers will usually seek medical advice from the medical director or clinical directors in the first instance, if any substantial doubt remains they shall seek advice from independent specialist medical advisers or the Royal Colleges, whether directly or through their regional advisers. (January 2001)	Implementation unknown.		

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Recommendations for Clinicians					
Improving NHS culture and governance	**37**	The Department of Health, the Royal Colleges and medical schools shall instruct members of the medical profession in the precise terms and provisions of the Coroner's Act 1988 and in particular the circumstances in which it is obligatory to report cases to the Coroner. (January 2001)	In January 2001, the Department of Health published advice from the Chief Medical Officer on the Removal Retention and use of Human Organs and Tissue from Post-mortem Examination. The recommendations of the Advice were accepted by the Government. The Advice recommended there should be a programme of education and training for all health professionals on the meaning of the law and appropriate standards of practice.	The Removal, Retention and use of Human Organs and Tissue from Post-mortem Examination, Department of Health, January 2001 Removal, retention and use of human organs and tissue, Department of Health, September 2003	
	38	Clinicians shall give the following basic information to the next of kin when a Coroner's post mortem examination is to be performed. • The nature of the examination, including the need to open the body and to remove and weigh organs. • The need for samples and possible retention of organs (January 2001)	In January 2001, the Department of Health published advice from the Chief Medical Officer on the Removal Retention and use of Human Organs and Tissue from Post-mortem Examination. The recommendations of the Advice were accepted by the Government. The Advice recommended that a Code of Practice, supported by Directions from the Secretary of State for Health under the National Health Service Act 1977, should be introduced as soon as possible, to set out the required standards of practice in communications with families about both hospital and coroners' post-mortems.	The Removal, Retention and use of Human Organs and Tissue from Post-mortem Examination, Department of Health, January 2001 Families and Post Mortems: A Code of practice, forms	

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			The Code of Practice, along with model consent forms and patient information leaflets, were published in April 2003. The Code of Practice stated that the discussion should include a basic explanation of what happens in a post-mortem examination and whether consent is to be given for retention or use of tissue or organs after the post-mortem, and for what purposes.	and information leaflets (2003) Removal, retention and use of human organs and tissue, Department of Health, September 2003	
	39	Clinicians wishing to retain organs or samples after the end of the Coroner's process for the purposes currently allowed under the Human Tissue Act 1961 shall follow the Recommendations in Chapter 10. (January 2001)	Implementation unknown.		
	40	Clinicians shall not mention to the next of kin the possibility of an examination under the Coroner's jurisdiction unless the death is reportable to the Coroner. (January 2001)	In January 2001, the Department of Health published advice from the Chief Medical Officer on the Removal Retention and use of Human Organs and Tissue from Post-mortem Examination. The recommendations of the Advice were accepted by the Government. The Advice recommended that a Code of Practice, supported by Directions from the Secretary of State for Health under the National Health Service Act 1977, should be introduced as soon as possible, to set out the required standards of practice in communications with families about both hospital and coroners' post-mortems. The Code of Practice did not address this recommendation.	The Removal, Retention and use of Human Organs and Tissue from Post-mortem Examination, Department of Health, January 2001 Families and Post Mortems: A Code of practice, forms	

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				and information leaflets (2003) Removal, retention and use of human organs and tissue, Department of Health, September 2003	
	41	Clinicians requesting a hospital post mortem examination after the Coroner has declined to authorise an examination shall make it clear to the next of kin that there is no compulsion remaining for such an examination. (January 2001)	In January 2001, the Department of Health published advice from the Chief Medical Officer on the Removal Retention and use of Human Organs and Tissue from Post-mortem Examination. The recommendations of the Advice were accepted by the Government. The Advice recommended that a Code of Practice, supported by Directions from the Secretary of State for Health under the National Health Service Act 1977, should be introduced as soon as possible, to set out the required standards of practice in communications with families about both hospital and coroners' post-mortems. The Code of Practice, along with model consent forms and patient information leaflets, were published in April 2003. The Code of Practice made provision for seeking consent from next of kin for hospital post-mortem examinations.	The Removal, Retention and use of Human Organs and Tissue from Post-mortem Examination, Department of Health, January 2001 Families and Post Mortems: A Code of practice, forms and information leaflets (2003) Removal, retention and use of human organs and tissue, Department of	

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				Health, September 2003	
	42	Clinicians shall explain the contents and implications of a Coroner's post mortem report to the next of kin as if the examination had been carried out as a hospital post mortem examination on their own recommendation. (January 2001)	In January 2001, the Department of Health published advice from the Chief Medical Officer on the Removal Retention and use of Human Organs and Tissue from Post-mortem Examination. The recommendations of the Advice were accepted by the Government. The Advice recommended that a Code of Practice, supported by Directions from the Secretary of State for Health under the National Health Service Act 1977, should be introduced as soon as possible, to set out the required standards of practice in communications with families about both hospital and coroners' post-mortems. The Code of Practice was published in April 2003 and made provision for the results meeting of a full hospital post-mortem examination but said in cases where a Coroners' post-mortem examination was ordered a full discussion might not be appropriate.	The Removal, Retention and use of Human Organs and Tissue from Post-mortem Examination, Department of Health, January 2001 Families and Post Mortems: A Code of practice, forms and information leaflets (2003) Removal, retention and use of human organs and tissue, Department of Health, September 2003	
Recommendations for Coroners					
	43	The Coroners' Society shall instruct Coroners that: • in the proper exercise of their judicial discretion, the decision to order a post	Implementation unknown.		

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		mortem examination is not to be delegated to Coroner's Officers and Deputy Coroners must be available at all times; • organs are not to be retained unless relevant to establishing the cause of death and only when specified by the pathologist in writing. (January 2001)			
	44	The Home Office and the Coroners' Society shall ensure all necessary medical education for Coroners. (January 2001)	Implementation unknown.		
	45	The Home Office and the Coroners' Society shall ensure all necessary training of Coroner's Officers and ancillary staff. (January 2001)	Implementation unknown.		
	46	Coroners shall be introduced, their function and procedures explained and the next of kin invited to express any specific concerns and requests. (January 2001)	In January 2001, the Department of Health published advice from the Chief Medical Officer on the Removal Retention and use of Human Organs and Tissue from Post-mortem Examination. The recommendations of the Advice were accepted by the Government. The Advice recommended that a Code of Practice, supported by Directions from the Secretary of State for Health under the National Health Service Act 1977, should be introduced as soon as possible, to set out the required standards of practice in communications with families about both hospital and coroners' post-mortems.	The Removal, Retention and use of Human Organs and Tissue from Post-mortem Examination, Department of Health, January 2001 Families and Post Mortems: A Code of practice, forms	

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			The Code of Practice was published in April 2003 and stated that a coroner's office or police officer would usually make contact with the family.	and information leaflets (2003) Removal, retention and use of human organs and tissue, Department of Health, September 2003	
	47	If a decision is made to authorise a post mortem examination Coroners shall ensure that the next of kin are advised of: • the reasons for authorising the post mortem examination; • their right to ask the Coroner that the examination be carried out by a pathologist independent of the hospital in which the deceased died; • the place and time of the examination and the identity of the pathologist; • the nature of the examination, including the need to open the body and to remove and weigh organs; • the need for samples and possible retention of organ; • their option to delay the funeral, while the pathologist fixes and examines any organs, to enable the return of the organs to the body for burial or cremation;	In January 2001, the Department of Health published advice from the Chief Medical Officer on the Removal Retention and use of Human Organs and Tissue from Post-mortem Examination. The recommendations of the Advice were accepted by the Government. The Advice recommended that a Code of Practice, supported by Directions from the Secretary of State for Health under the National Health Service Act 1977, should be introduced as soon as possible, to set out the required standards of practice in communications with families about both hospital and coroners' post-mortems. The April 2003 Code of Practice provided that where a Coroners' post-mortem examination was carried out the reasons for the post-mortem and the procedure to be followed should be explained to the family, and that they should also be given information about when and where the examination is to be performed and their right to be represented at the post-mortem by a medical practitioner. The Code of Practice also advised that whenever possible the family should be asked before a Coroners' post-mortem	The Removal, Retention and use of Human Organs and Tissue from Post-mortem Examination, Department of Health, January 2001 Families and Post Mortems: A Code of practice, forms and information leaflets (2003) Removal, retention and use of human organs and tissue, Department of	

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		• their option for a funeral without the return of the organs, in which case they shall be invited to consent to respectful disposal by the Coroner; • their option to make their own arrangements for respectful disposal of the organs. (January 2001)	took place whether they might agree to the subsequent retention of tissue and organs removed. Under revisions to the Coroner's Rules made in 2005, a coroner who ordered a post-mortem examination had a duty to inform the relatives or personal representative of the deceased person before the post-mortem is carried out: that the material was being kept; the period or periods for which it needs to be kept; the options for dealing with the material once it is no longer required for the coroner's purposes.	Health, September 2003	
	48	If a decision is made not to authorise a post mortem examination, Coroners shall notify the next of kin of that decision and give sufficient reasons for the decision. (January 2001)	The Department of Health's April 2003 Code of Practice did not address this recommendation, nor did the Human Tissue Authority's Code of Practice published in July 2006.	Families and Post Mortems: A Code of practice, forms and information leaflets (2003) Code of Practice - Post mortem examination, Human Tissue Authority, July 2006	
	49	Coroners shall ensure the expeditious examination and recording of samples and organs. (January 2001)	The Human Tissue Authority published its Code of Practice for post-mortem examinations in July 2006, which provided that establishments should ensure that systems are in place to maintain proper records and documentation for all tissue and organs they acquire and/or pass on to others. The Designated Individual named in licences issued by the	Code of Practice - Post mortem examination, Human Tissue Authority, July 2006	

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			Human Tissue Authority must ensure that such systems are in place		
	50	Coroners shall establish efficient systems for securing final post mortem reports following histological examination. (January 2001)	Implementation unknown.		
	51	Coroners shall ensure that all existing retained organs, tissue, blocks, slides, photographs and X-rays are specified within any preliminary and final post mortem reports. (January 2001)	The Royal College of Pathologists published guidelines in March 2000 for the retention of tissues and organs at post-mortem examination. It recommended that reports of post-mortem examinations required by law should state clearly what, if any, tissues or organs had been retained in pursuance of the investigation of death.	Guidelines for the retention of tissues and organs at post-mortem examination, The Royal College of Pathologists, March 2000.	
Recommendations for Pathologists					
	52	The Royal College of Pathologists shall instruct all practising histopathologists that they shall not retain samples and organs beyond those reasonably incidental to establishing the cause of death unless there is also written consent properly obtained under the Human Tissue Act 1961. (January 2001)	The Royal College of Pathologists published guidelines for the retention of tissues and organs at post-mortem examination in March 2000, advising that agreement must be obtained for retention of samples if the primary purpose of retention was for teaching, training, research or treatment.	Guidelines for the retention of tissues and organs at post-mortem examination, The Royal College of Pathologists, March 2000.	
Recommendations in Relation to the Human Tissue Act					
	53	The Department of Health, the Royal Colleges and medical schools shall instruct members of the	In January 2001, the Department of Health published advice from the Chief Medical Officer on the Removal	The Removal, Retention and use	

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		medical profession in the precise terms and provisions of the Human Tissue Act 1961, on the basis of our analysis, and the need for strict compliance. (January 2001)	Retention and use of Human Organs and Tissue from Post-mortem Examination. The recommendations of the Advice were accepted by the Government. The Advice recommended there should be a programme of education and training for all health professionals on the meaning of the law and appropriate standards of practice.	of Human Organs and Tissue from Post-mortem Examination, Department of Health, January 2001 Removal, retention and use of human organs and tissue, Department of Health, September 2003	
	54	The Human Tissue Act 1961 shall be amended to provide a test of fully informed consent for the lawful post mortem examination and retention of parts of the bodies of deceased persons. While we have concluded that there has been little difference between 'lack of objection' and 'informed consent' in practical terms for the next of kin, it is important that the law and future practice are brought into line and updated. (January 2001)	The Government enacted the Human Tissue Act 2004, which implemented a test of consent.	Human Tissue Act 2004	
	55	The class of persons relevant to the obtaining of fully informed consent shall be defined as the 'next of kin'. (January 2001)	The Government enacted the Human Tissue Act 2004, which defined the class of persons relevant to the obtaining of consent as those in "qualifying relationships", a list of which was provided in the Act in ranked order.	Human Tissue Act 2004	

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	56	The class of 'any surviving relative' shall no longer be relevant to post mortem examination. (January 2001)	The Government enacted the Human Tissue Act 2004, which defined the class of persons relevant to the obtaining of consent as those in "qualifying relationships", a list of which was provided in the Act in ranked order.	Human Tissue Act 2004	
	57	There shall be a programme of health education for the public relevant to the medical need for continued post mortem examination and access to organs and samples for therapeutic, educational and research purposes. (January 2001)	In January 2001, the Department of Health published advice from the Chief Medical Officer on the Removal Retention and use of Human Organs and Tissue from Post-mortem Examination. The recommendations of the Advice were accepted by the Government. The Advice recommended there be a programme of public education to ensure there is general understanding of what is involved in the post-mortem process and its value to maintaining standards of patient care and medical science.	The Removal, Retention and use of Human Organs and Tissue from Post-mortem Examination, Department of Health, January 2001 Removal, retention and use of human organs and tissue, Department of Health, September 2003	
	58	The Department of Health, the Royal Colleges and medical schools shall provide training for all those involved in obtaining fully informed consent. (January 2001)	In January 2001, the Department of Health published advice from the Chief Medical Officer on the Removal Retention and use of Human Organs and Tissue from Post-mortem Examination. The recommendations of the Advice were accepted by the Government.	The Removal, Retention and use of Human Organs and Tissue from Post-mortem Examination, Department of	

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			The Advice recommended there should be a programme of education and training for all health professionals on the meaning of the law and appropriate standards of practice.	Health, January 2001 Removal, retention and use of human organs and tissue, Department of Health, September 2003	
	59	The Human Tissue Act 1961 shall be amended to impose a criminal penalty by way of fine for breach of its provisions in order to encourage future compliance. (January 2001)	The Government enacted the Human Tissue Act 2004, which created a number of offences including if, without appropriate consent, a person performed a relevant activity without reasonable belief they had appropriate consent to do the same.	Human Tissue Act 2004	
	60	Guidelines relating to the requirements of the Human Tissue Act 1961 and the obtaining of fully informed consent shall be drawn up and provision made for breach to result in disciplinary proceedings which could lead to suspension, dismissal or financial penalty(January 2001)	The Human Tissue Authority published 8 codes of practice in 2006, including a code of practice on consent.	Human Tissue Authority Codes of Practice, 2006	
	61	The Human Rights Act 1998 makes provision for an effective remedy other than in criminal proceedings. If breaches of the Human Tissue Act 1961 amount to breaches of the Human Rights Act 1998 consideration shall be given to incorporating a financial remedy with the Human Tissue Act 1961	The Human Tissue Act 2004 did not provide a civil remedy for breaches of it.	Human Tissue Act 2004	

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		itself. If necessary, reference should be made to the Law Commission. (January 2001)			
Recommendations in Relation to Consent					
	62	Following examination of the retained organs or tissue, there should be a meeting between the clinician and parents and referral for genetic counselling or other specialist advice if appropriate. (January 2001)	Implementation unknown.		
	63	Once fully informed consent is obtained for research purposes, the researchers are entitled to remain in possession of the material retained while research continues. We recommend this extends to accessing archives and DNA analysis. All research remains subject to ethics committee approval. (January 2001)	This was reflected in part in the Human Tissue Authority's consent code of practice, published in July 2006.	Human Tissue Authority Codes of Practice, 2006	
	64	Local ethics committees should be given a supervisory role to police approved research. (January 2001)	Implementation unknown.		
Recommendations for Bereavement Advisers					
	65	All trusts should designate a named individual who will be available to provide support and information to families of the deceased where post mortem examination may be required, where this is requested by a hospital doctor or the Coroner. This	Interim Guidance on Post-Mortem Examinations was published by the Department of Health in March 2000 and required NHS trusts to designate a named individual to provide support and information to families of the deceased where a post-mortem examination might be required.	Department of Health Chief Medical Officer - Organ Retention: Interim Guidance on Post-mortem	

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		designated person should be a bereavement adviser. (January 2001)	In January 2001, the Department of Health published advice from the Chief Medical Officer on the Removal Retention and use of Human Organs and Tissue from Post-mortem Examination. The Advice stated that many NHS Trusts had designated such an individual, but the further recognition of the importance of the role of a bereavement adviser and provision of standard professional training might be needed. The Advice repeated the recommendation that all NHS Trusts should provide the support of a bereavement adviser.	Examination to the NHS The Removal, Retention and use of Human Organs and Tissue from Post-mortem Examination, Department of Health, January 2001	
	66	The functions of a bereavement adviser should include: • Explaining the circumstances of death, identifying when, where and who was present. • Arranging and attending a meeting for relatives with anyone who was present at the death if requested. • Encouraging a meeting between relatives and the treating clinician to explain the clinical circumstances of death and, if requested, arranging and attending the meeting. • Ensuring that relatives have a full explanation of the reasons for post mortem examination including therapeutic, medical education and research.	Both Interim Guidance on Post-Mortem Examinations published by the Department of Health in March 2000 and the January 2001 advice from the Chief Medical Officer on the Removal Retention and use of Human Organs and Tissue from Post-mortem Examination set out a list of the roles of a bereavement adviser.	Department of Health Chief Medical Officer - Organ Retention: Interim Guidance on Post-mortem Examination to the NHS (2000) The Removal, Retention and use of Human Organs and Tissue from Post-mortem Examination, Department of Health, January 2001	

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		• Explaining the need for consent to carry out a hospital post mortem examination and the retention of organs. • Explaining that consent is necessary for the retention of organs following a Coroner's post mortem examination and that the consent must be obtained before the Coroner's post mortem examination is undertaken. • Ensuring relatives have sufficient time, privacy and support to reflect upon the request for consent to an hospital post mortem examination or the retention of organs following a Coroner's post mortem examination or an hospital post mortem examination. • Ascertaining whether a clinician will attend the post mortem examination. • Facilitating meetings between parents, clinician and pathologist as appropriate. • Noting discussions between relatives, clinicians and pathologists and providing a copy to each party involved. • Developing and using information packs for relatives on all aspects of death in hospital. • Assisting relatives in the following practical matters: collecting the deceased's personal belongings and arranging return to relatives; ensuring provision of certificate of death and the formal notice; explaining the procedure to register the death; providing support in attending the registry office if requested;			

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		arranging contact with funeral director; arranging contact with hospital chaplain and/or local priest as required; contacting the Coroner's office as appropriate; offering to attend if contact with police necessary; ensuring that the General Practitioner is informed; ensuring that schools are informed as appropriate (including the schools of siblings); assisting the relatives in informing other persons including other relatives, friends and employers, of the death and its consequences; assisting the relatives in dealing with the Benefits Agency, insurance company and housing matters; assisting the relatives to place announcements in newspapers if wished. Discussing counselling or long-term support needs with relatives, including the needs of wider family members and making contact with appropriate counselling/support agencies if requested. • Ensuring that relatives are aware of the full range of counselling/support resources available, including those external to the hospital and bringing these matters to the attention of the relatives. • Accessing translation/interpreting services including services for people with hearing or visual impairment and providing appropriate written/taped information. • Assisting with any other individual problem presented by relatives in consequence of death.			

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		• Undertaking general liaison duties (January 2001)			
	67	There must be recognised training courses for bereavement advisers. Qualification should be certificated, perhaps at a National Vocational Qualification level. Annual assessment and appraisal should be routine and the role should be performance managed. Continuing education and training is essential. The bereavement adviser should work closely with the hospital management, clinicians, the Coroner and the full range of non-medical services including counsellors and other non-medical professionals. There will of course be relatives who do not wish to avail themselves of the services of a bereavement adviser. Nevertheless the service should be offered to everyone, as should the facility to return to the bereavement adviser in the event of their services having been declined in the first instance. (January 2001)	In January 2001, the Department of Health published advice from the Chief Medical Officer on the Removal Retention and use of Human Organs and Tissue from Post-mortem Examination. The Advice stated that many NHS Trusts had designated such an individual, but that further recognition of the importance of the role of a bereavement adviser and provision of standard professional training might be needed. The Advice said that training would be needed to understand the different views of death in different cultures; to understand the post-mortem procedures and issues of consent; and in the psychological component of sensitive and respectful communication.	The Removal, Retention and use of Human Organs and Tissue from Post-mortem Examination, Department of Health, January 2001	
	67	The distinction between a cardiac liaison nurse and the bereavement adviser is that the nurse has the advantage of contact with the parents in the period prior to death. We suggest that some aspect of the bereavement adviser's multi-factorial function will bring them into contact with the parents before the death of their child. (January 2001)	Implementation unknown.		

6 BRISTOL ROYAL INFIRMARY INQUIRY

6.1 Introduction

A public inquiry set up to investigate the management of the care of children receiving complex cardiac services at the Bristol Royal Infirmary between 1984 and 1996. The Inquiry was chaired by Professor Sir Ian Kennedy. The report of the Inquiry was delivered in July 2001. The report can be viewed online.

The Inquiry was tasked with:

- Making findings as to the adequacy of the paediatric cardiac surgical services provided by Bristol Royal Infirmary;
- Establishing what action was taken both within and outside the hospital to deal with concerns raised and to identify any failure to take action promptly; and
- Reaching conclusions from these events and making recommendations to help secure high-quality care across the NHS.

The Inquiry found that the paediatric cardiac surgical service at Bristol Royal Infirmary was less than adequate. There was poor teamwork, with implications for performance and outcome including a significantly higher mortality rate for open-heart surgery. The systems and culture in place were such as to make open discussion and review more difficult. Communication between parents and some staff was poor. At national level, there was confusion as to who was responsible for monitoring quality of care, which a lack of any real system whereby an organisation took responsibility for keeping an eye on things.

The Inquiry made 198 recommendations. The Government responded to the report of the Inquiry, and the recommendations it made, in its January 2002 report titled '*Learning from Bristol: The Department of Health's Response to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*'.

6.2 Bristol Royal Infirmary Inquiry: Table of Recommendations

Bristol Royal Infirmary Inquiry					
Type of Recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
Improving patient safety	**1**	In a patient-centred healthcare service, patients must be involved, wherever possible, in decisions about their treatment and care. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it had introduced a 'good practice in consent' initiative to ensure patients were able to be involved in their own healthcare decisions. The Department of Health also referred to guidance for patients on consent being available throughout the NHS and the issuing of a model consent policy and model consent forms in November 2001. Implementation was to be monitored through clinical governance, the Clinical Negligence Scheme for Trusts, the Controls Assurance Framework and inspection by the Commission for Healthcare Improvement.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**2**	The education and training of all healthcare professionals should be imbued with the idea of partnership between the healthcare professional and the patient. (July 2001)	The Government agreed with this recommendation. In its January 2002 Response, the Department of Health said that the NHS Plan 2000 stressed the importance of communicating well with patients and their families, and this would be reflected in education and training programmes as part of basic training and as part of continuing professional development.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**3**	The notion of partnership between the healthcare professional and the patient, whereby the patient and the professional meet as equals with different	The Government agreed with this recommendation.	The Department of Health's Response	

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		expertise, must be adopted by healthcare professionals in all parts of the NHS. (July 2001)	In its January 2002 response, the Department of Health said that a new core curriculum would be in place by 2002 to help break down traditional barriers between health professionals and patients, with the Expert Patient Programme introduced to support patients in this relationship.	to the BRI Inquiry, January 2002.	
Improving patient safety	**4**	Information about treatment and care should be given in a variety of forms, be given in stages and be reinforced over time. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that the model consent policy required NHS organisation to make good quality up to date information available to patients in a variety of forms, making it that consent was a continuing process, not a one-off event.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**5**	Information should be tailored to the needs, circumstances and wishes of the individual. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that from April 2003 information would be made available through a new National Knowledge Service in a number of languages aimed at different levels of understanding.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**6**	Information should be based on the current available evidence and include a summary of the evidence and data, in a form which is comprehensible to patients. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that a new National Knowledge Service for the NHS would provide a framework for identifying and meeting the needs for knowledge to support patient care.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Improving patient safety	**7**	Various modes of conveying information, whether leaflets, tapes, videos, or CDs should be regularly updated, and developed and piloted with the help of patients. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that wider access to information was being developed through a range of technologies, including NHS Direct Information Points and Information channels on bedside TVs.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**8**	The NHS Modernisation Agency should make the improvement of the quality of information for patients a priority. In relation to the content and the dissemination of information for patients, the Agency should identify and promote good practice throughout the NHS. It should establish a system for accrediting materials intended to inform patients. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that promoting good practice throughout the NHS in relation to quality of information for patients was an integral part of all NHS Modernisation Agency programmes.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**9**	The public should receive guidance on those sources of information about health and healthcare on the Internet which are reliable and of good quality: a kitemarking system should be developed. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that a new National Knowledge Service would integrate existing systems, with NHS Direct Online accrediting some material with planned extension from 2003.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**10**	Tape-recording facilities should be provided by the NHS to enable patients, should they so wish, to make a tape recording of a discussion with a healthcare professional when a diagnosis, course	The Government rejected this recommendation. In its January 2002 response, the Department of Health said this proposal could undermine the relationship of trust between patient and health care professional.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		of treatment, or prognosis is being discussed. (July 2001)			
Improving patient safety	**11**	Patients should always be given the opportunity and time to ask questions about that they are told, to seek clarification and to ask for more information. It must be the responsibility of employers in the NHS to ensure that the working arrangements of healthcare professionals allows for this, not least that they have the necessary time. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that the new model consent forms made clear that patients should be encouraged to ask questions and raise any concerns they had. The Department said it was investing significant resources to increase the number of doctors, nurses and therapists.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**12**	Patients must be given such information as enables them to participate in their care. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that the steps outlined in response to recommendations 1 to 11 would help ensure patients have access to information while receiving care, with new guidance on consent to make clear that patients must have sufficient information on any proposed procedure before their consent to treatment is sought.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**13**	Before embarking on any procedure, patients should be given an explanation of what is going to happen and, after the procedure, should have the opportunity to review what has happened. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to its initiative to improve communication within the NHS and said it would ensure that it was built into training at all levels.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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	14	Patients should be supported in dealing with the additional anxiety sometimes created by greater knowledge. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that health care staff were trained to respond to the emotional and spiritual needs of their patients and provide support. The Department said that a working group including patients, doctors, nurses, hospital records management staff and representatives of professional organisations was set up in July 2001 to address how best to support patients in dealing with the anxiety sometimes caused by greater knowledge, with the working group to produce its guidelines by summer 2002.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**15**	Patients should be told that they may have another person of their choosing present when receiving information about a diagnosis or a procedure. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to a patient's leaflet published in July 2001 encouraging patient to take someone with them to a consultation if they wished.	The Department of Health's Response to the BRI Inquiry, January 2002.	
	16	Patients should be given the sense of freedom to indicate when they do not want any (or more) information: this requires skill and understanding from help professionals. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to its initiative to improve communication within the NHS and said it would ensure that it was built into training at all levels.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**17**	Patients should receive a copy of any letter written about their care or treatment by one healthcare professional to another. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that a working group including patients, doctors,	The Department of Health's Response	

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			nurses, hospital records management staff and representatives of professional organisations was set up in July 2001 to produce guidelines on copying clinicians' letters to patients and set out arrangements for parents to receive copies of letters, with the working group to produce its guidelines by summer 2002. Good practice guidelines were published in April 2003, providing a general rule that, where patients agree, letters written by one health professional to another about a patient should be copied to the patient, or where appropriate a parent.	to the BRI Inquiry, January 2002. Copying letters to Patients, Department of Health, April 2003.	
Improving patient safety	**18**	Parents of those too young to take decision for themselves should receive a copy of any letter written by one healthcare professional to another about their child's treatment or care. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that a working group including patients, doctors, nurses, hospital records management staff and representatives of professional organisations was set up in July 2001 to produce guidelines on copying clinicians' letters to patients and set out arrangements for parents to receive copies of letters, with the working group to produce its guidelines by summer 2002. Good practice guidelines were published in April 2003, providing a general rule that, where patients agree, letters written by one health professional to another about a patient should be copied to the patient, or where appropriate a parent.	The Department of Health's Response to the BRI Inquiry, January 2002. Copying letters to Patients, Department of Health, April 2003.	

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Improving patient safety	**19**	Healthcare professionals responsible for the care of any particular patient must communicate effectively with each other. The aim must be to avoid giving the patient conflicting advice and information. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that its communications initiative would ensure patients were at the focus of team working and inter-professional care, with healthcare professionals developing these skills through joint learning.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**20**	The provision of counselling and support should be regarded as an integral part of a patient's care. All hospital trusts should have a well-developed system and a well-trained group of professionals whose task it is to provide this type of support and to make links to the various other forms of support (such as that provided by voluntary or social services) which patients may need. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that the Patient Advocacy and Liaison Service would provide an accessible service (including counselling) to patients and their families, to be introduced into every NHS trust and primary care trust from April 2002.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS Culture and governance	**21**	Every trust should have a professional bereavement service. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it was mapping the quality and quantity of bereavement services to determine where specific improvements were needed. The Department also said that work was progressing to develop a Code of Practice on communicating with families about post-mortems.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**22**	Voluntary organisations which provide care and support to patients in the NHS play a very important role. Groups which meet the appropriate standards as laid down by the NHS should receive appropriate	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that voluntary organisations could already be funded	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		funding from the state for the contribution they make to the NHS. (July 2001)	to provide such services as an alternative to the NHS providing the services itself.		
Improving patient safety	**23**	We note and endorse the recent statement on consent produced by the Department of Health: '*Reference guide to consent for examination or treatment'*, 2002. It should inform the practice of all healthcare professionals in the NHS and be introduced into practice in all trusts. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to its model consent policy, issued in November 2001, requiring NHS organisations to consider the procedural factors which would affect how patients actually experienced the consent process.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**24**	The process of informing the patient, and obtaining consent to a course of treatment, should be regarded as a process and not a one-off event consisting of obtaining a patient's signature on a form. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that its Reference Guide and model consent policy both made clear that consent was a process, with the signing of a consent form only the end point.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**25**	The process of consent should apply not only to surgical procedure but to all clinical procedure and examinations which involve any form of touching. This must not mean more forms: it means more communication. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that its Reference Guide and model consent policy made clear that consent should always be sought before any kind of personal care or treatment was offered.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**26**	As part of the process of obtaining consent, except when they have indicated otherwise, patients should be given sufficient information about what is to take place, the risks, uncertainties, and possible negative consequences of the proposed treatment,	The Government agreed with this recommendation. In its January 2002 response, the Department of health referred to the new model consent forms, issued in November 2001, as making clear that patients should be informed about benefits, risks, what the treatment would	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		about any alternatives and about the likely outcome, to enable them to make a choice about how to proceed. (July 2001)	involve and about alternative treatments if available. Controls Assurance, the Clinical Negligence Scheme for Trusts, and clinical governance and Commission for Healthcare Improvement inspections were to ensure that the forms were used in all trusts.		
Improving patient safety	**27**	Patients should be referred to information relating to the performance of the trusts, of the speciality and of the consultant unit (a consultant and the team of doctors who work under his or her supervision). (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to a range of new developments said to be contributing to the collection of better information about the performance of NHS trusts, including annual publication of performance indicators for all acute trusts, the clinical governance reviews undertaken by the Commission for Healthcare Improvement and the publication of improved clinical indicators. The Department also said it had collaborated with 'Dr Foster' on a number of initiatives and was working with the Royal Colleges with a view to publication of consultant-specific data.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving the ability to raise complaints and concerns	**28**	Patients must be given the opportunity to pass on views on the service which they have received: all parts of the NHS should routinely seek and act on feedback from patients as to their views of the service. In addition, formal, systematic structured surveys of patients' experience of their care (not merely satisfaction surveys) should be routinely conducted across the NHS and the results made public. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that, starting 2002, every acute hospital trust would undertake an annual patient survey. The Department also said it had introduced legislation to establish Patients' Forums in every NHS trust and primary care trust by April 2003.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Improving the ability to raise complaints and concerns	**29**	NHS trusts and primary care trusts must have systems which ensure that patients know where and to whom to go when they need further information or explanation. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that, from April 2002, every NHS trust and primary care trust would have a Patient Advocacy and Liaison Service to help and advise patients, their carers and families.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving the ability to raise complaints and concerns	**30**	We endorse the initiative in '*The NHS Plan*' to establish a Patient Advocacy and Liaison Service in every NHS trust and primary care trust. The establishment of this service should be implemented in full as quickly as possible. Once established, patient advocacy and liaison services must be given secure funding to enable them to provide an effective service to patients. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that £10m was allocated in 2001/2 to establish 100 'pathfinder' Patient Advocacy and Liaison Services. The Department of Health said that, from April 2002, every NHS trust and primary care trust would have a Patient Advocacy and Liaison Service, with future funding to be through normal trust allocations.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving the ability to raise complaints and concerns	**31**	Trust and primary care trusts must have systems for publishing periodic reports on patients' views and suggestions, including information about the action taken in the light of them. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that from 2002/3, every trust should publish a new Patient Prospectus, including an annual account of patients' views and local standards set specifically to address shortfalls identified through the patient survey.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving the ability to raise complaints and concerns	**32**	So as to provide for patients an effective, efficient and seamless information and advocacy service, consideration should be given to how the various patient advocacy and liaison services in a given geographical area could most effectively	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that primary care trust patient and advocacy liaison	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		collaborate, including in relation to the provision of information for patients and the public. (July 2001)	services would be expected to act as leads, coordinating effective collaboration across their areas.		
Improving NHS culture and governance	**33**	A duty of candour, meaning a duty to tell a patient if adverse events have occurred, must be recognised as owed by all those working in the NHS to patients. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to the entitlement of patients to a full explanation and apology when something went wrong, whether or not they wished to make a complaint. No statutory duty of candour was implemented until enactment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.	The Department of Health's Response to the BRI Inquiry, January 2002. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	
Improving NHS culture and governance	**34**	When things go wrong, patients are entitled to receive an acknowledgement, an explanation and an apology. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to the entitlement of patients to a full explanation and apology when something went wrong, whether or not they wished to make a complaint. The Department said that current complaints procedure provided for acknowledgements to be made within 2 days; full investigation and resolution within 20 working days; and an explanation and/or apology to be offered as appropriate.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving the ability to raise complaints and concerns	**35**	There should be a clear system, in the form of a 'one-stop shop' in every trust, for addressing the concerns of a patient about the care provided by, or the conduct of, a healthcare professional. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to the implementation of the Patient Advocacy and	The Department of Health's Response to the BRI Inquiry, January 2002.	

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			Liaison Service, to be in place in every NHS trust by April 2002.		
Improving the ability to raise complaints and concerns	**36**	Complaints should be dealt with swiftly and thoroughly, keeping the patient (and carer) informed. There should be a strong independent element, not part of the trust's management or board, in any body considering serious complaints which require formal investigation. An independent advocacy service should be established to assist patients (and carers). (July 2001)	The Government agreed with this recommendation in part. In its January 2002 response, the Department of Health said it was reviewing the NHS complaints system, including looking at strengthening the independent review stage. The Department referred to the implementation of Patient Advocacy and Liaison Service, which would be available to assist patients through the complaints process.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving the ability to raise complaints and concerns	**37**	There should be an urgent review of the system for providing compensation to those who suffer harm arising out of medical care. The review should be concerned with the introduction of an administrative system for responding promptly to patients' needs in place of the current system of clinical negligence and should take account of other administrative systems for meeting the financial needs of the public. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it had announced plans to produce a White Paper early in 2002, discussing options for reform to the system for dealing with clinical negligence claims. A report was published by the Department of Health in July 2003, setting out proposals for reforming the approach to clinical negligence in the NHS. The NHS Redress Act 2006, containing provisions for the establishment of a redress scheme outside the scope of civil proceedings, was enacted but never brought into force.	The Department of Health's Response to the BRI Inquiry, January 2002. Making amends: a consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS: Department of Health, July 2003 NHS Redress Act 2006.	

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Improving NHS culture and governance	**38**	The Department of Health's role in relation to the NHS must in future be made explicit. The Department of Health should have two roles. It should be the headquarters of the NHS. It should also establish an independent framework of regulation which will assure the quality of the care provided in and funded by the NHS, and the competence of healthcare professionals. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it would be responsible for setting the overall direction for the NHS, securing its funding, determining major investments and ensuring that there are appropriate arrangements in place for its management, standard setting, inspection, improvement and accountability. The Department said it would be responsible for ensuring the various bodies responsible for these different functions worked together to provide a consistent framework of high delivery health improvement.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**39**	The framework of regulation must consist of two overarching organisations, independent of government, which bring together the various bodies which regulate healthcare. A Council for the Quality of Healthcare should be created to bring together those bodies which regulate healthcare standards and institutions (including for example, the Commission for Health Improvement, the National Institute for Clinical Excellence and the proposed National Patient Safety Agency). A Council for the Regulation of Healthcare Professionals should be created to bring together those bodies which regulate healthcare professionals (including, for example, the General Medical Council and the Nursing and Midwifery	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that proposals for the creation of the Council for the Regulation of Health Care Professionals was published in August 2001. The Health Professionals Council was set up in 2003, under the National Health Service Reform and Health Care Professions Act 2002. It was not independent from Government, but rather to be an arms-length body from the Department of Health.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Regulation and oversight of NHS managers		Council); in effect, this is the body currently referred to in 'The NHS Plan' as the Council of Healthcare Regulators. These overarching organisations must ensure that there is an integrated and co-ordinated approach to setting standards, monitoring performance, and inspection and validation. Issues of overlap and of gaps between the various bodies must be addressed and resolved. (July 2001)	The Commission for Healthcare Audit and Inspection was created in 2004 under the Health and Social Care (Community Health and Standards) Act 2004.		
Improving NHS culture and governance	**40**	The two Councils should be independent of government and report both the Department of Health and to Parliament. There should be close collaboration between the two Councils. The Department of Health should establish and fund the Councils and set their strategic framework, and thereafter periodically review them. (July 2001)	The Government agreed with this recommendation in principle. In its January 2002 report, the Department of Health said it would establish a fund a new administrative Council for Quality of Health Care in 2002 to ensure coordination between the Council for the Regulation of Health Care Professionals and other organisations with an interest in service quality. This was to be at arm's length from the Department of Health rather than independent. The Council for the Regulation of Health Care Professionals would be independent and report to Parliament. The Health Professionals Council was subsequently set up in 2003, under the National Health Service Reform and Health Care Professions Act 2002.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**41**	The various bodies whose purpose it is to assure the quality of care in the NHS (for example, the Council for Health Improvement and the National Institute for Clinical Excellence) and the competence of healthcare professionals (for	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said professional regulatory bodies would remain independent from the Department of Health. The Council	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		example, the General Medical Council and the Nursing and Midwifery Council) must themselves be independent of and at arm's-length from the Department of Health. (July 2001)	for Health Improvement would remain a non-departmental public body and the National Institute for Clinical Excellence would remain a special health authority.		
Improving NHS culture and governance	**42**	All the various bodies and organisations concerned with regulation, besides being independent of government, must involve and reflect the interests of patients, the public and healthcare professionals, as well as the NHS and government. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that proposals for the new Nursing and Midwifery and Health Professions Councils and reform of the General Medical Council included arrangements for reflecting the interests of patients, the public and healthcare professionals.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**43**	The contractual relationship between trusts and consultants should be redefined. The trust must provide the consultant with the time, space and the necessary tools to do the job. Consultants must accept that the time spent in the hospital and what they do in that time must be explicitly set out. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to Government proposals for a new consultant contract, with all consultants' job plans explicitly setting out how their working time should be organised and what support the trust should provide.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**44**	The system of Distinction Awards for hospital consultants should be examined to determine whether it could be used to provide greater incentives than exist at present for providing good quality of care to patients. The possibility of its extension to include junior hospital doctors should be explored. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to new NHS Clinical Excellence Awards, which would reward those who make the biggest contribution to delivering and improving health services in terms of leadership and clinical excellence.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Improving NHS culture and governance	**45**	The doctors' Code of Professional Practice, as set down in the General Medical Council's 'Good Medical Practice', should be incorporated into the contract of employment between doctors and trusts. In the case of GPs, the terms of service should be amended to incorporate the Code. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said that the standard documentation for consultants' appraisal, a contractual requirement from April 2001, already explicitly included the headings set out in the General Medical Council's 'Good Medical Practice' and the same principles would apply to other NHS doctors including GPs where appraisal is under negotiation.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**46**	The relevant codes of practice for nurses, for professions allied to medicine and for managers should be incorporated into their contracts of employment with hospital trusts or primary care trusts. (July 2001)	The Government agreed with this recommendation in principle. In its January 2002 response, the Department of Health said that contracts of employment for healthcare professionals were already based on the premise that they were properly registered with their regulatory body. The Department said that many contracts included this specific provision, but that it was implicit in all contracts of employment.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**47**	Trusts should be able to deal as employers with breaches of the relevant professional code by a healthcare professional, independently of any action which the relevant professional body may take. (July 2001)	The Government agreed with this recommendation in principle. In its January 2002 response, the Department of Health said that it expected local employers to take into account professional codes of practice in their local codes of conduct.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Regulation and oversight of NHS managers	**48**	The security of tenure of the chief executive and senior managers of trusts should be on a par with that of other senior professionals in the NHS. (July 2001)	The Government agreed with this recommendation in principle. In its January 2002 response, the Department of Health said it was considering this issue in more detail as part of work to develop a new framework for senior managers' contracts.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Regulation and oversight of NHS managers	**49**	The criteria and process for selection of the executive directors of a trust board must be open and transparent. Appointments should be made on the basis of ability and not on the basis of seniority.	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that appointment procedures were rigorous, referring to guidance issued in December 1997.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**50**	The NHS Leadership Centre, in conjunction with trusts, should develop programmes of training and support for clinicians and others who seek to become executive directors. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said an executive director development programme was commencing in January 2002.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Regulation and oversight of NHS managers	**51**	As recommended in 'The NHS Plan', there should be an NHS Appointments Commission responsible for the appointment of non-executive directors of NHS trusts, health authorities and primary care trusts. (July 2001)	The Government agreed with this recommendation. The NHS Appointments Commission was established in April 2001.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**52**	Newly appointed non-executive directors of trusts, health authorities and primary care trusts should receive a programme of induction: this should refer to the principles and values of the NHS and their	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said an induction guide for chairs and non-executive directors was being developed by the NHS Leadership	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		duties and responsibilities with regard to the quality of care provided by the trust. This programme should be provided through the NHS Leadership Centre. (July 2001)	Centre and the NHS Appointments Commission, to be published in January 2002.		
Improving NHS culture and governance	**53**	A standard job description should be developed by the NHS for non-executive directors, as proposed in 'The NHS Plan'. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that a standard description for chairmen and non-executive directors had been developed and was in use.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**54**	Throughout their period of tenure, non-executive directors should be provided with training, support and advice organised and co-ordinated through the NHS Leadership Centre. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that the NHS Leadership Centre would continue working with Regional Commissioners in the design of development initiatives for non-executive directors.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**55**	The Chairs of trust boards should have a source of independent advice (or mentor) during their period of office, drawn from a pool of experts assembled by the NHS Leadership Centre. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said the NHS Leadership Centre would act as broker in matching chairs of trust boards with mentors or sources of independent advice.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**56**	Arrangements should be in place in the standing orders of trust boards to provide for proper continuity in the management of the trust's affairs in the period between the cessation of the Chair's term	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said the NHS Appointments Commission would ensure that	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		of office and the commencement of that of a successor. (July 2001)	there was rarely a gap between retirement of a chairman and appointment of a successor.		
Improving NHS culture and governance	**57**	Greater priority than at present should be given to non-clinical aspects of care in six key areas in the education, training and continuing professional development of healthcare professionals: • Skills in communicating with patients and with colleagues; • Education about the principles and organisation of the NHS, and about how care is managed, and the skills required for management; • The development of teamwork; • Shared learning across professional boundaries; • Leadership. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it was working with regulatory and professional bodies and educators to ensure that from 2002 these core skills were included in all NHS-funded professional programmes and clinical undergraduate training.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**58**	Competence in non-clinical aspects of caring for patients should be formally assessed as part of the process of obtaining an initial professional qualification, whether as a doctor, a nurse or some other healthcare professional. (July 2001)	The Government agreed with his recommendation. In its January 2002 response, the Department of Health said the non-clinical aspects of care were already a core part of the training of health professionals, and that it was working with the professions and educationalists to strengthen non-clinical aspects of care.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**59**	Education in communication skills must be an essential part of the education of all healthcare professionals. Communication skills include the	The Government agreed with this recommendation.	The Department of Health's Response	

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		ability to engage with patients on an emotional level to listen, to assess how much information a patient wants to know, and to convey information with clarity and sympathy. (July 2001)	In its January 2002 response, the Department of Health said that education in communication skills was a core feature of professional training, and that it had begun a major new communications skills initiative to encompass all NHS Staff.	to the BRI Inquiry, January 2002.	
Improving patient safety	**60**	Communication skills must also include the ability to engage with and respect the views of fellow healthcare professionals. (July 2001)	The Government agreed with this recommendation.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**61**	The education, training and Continuing Professional Development of all healthcare professionals should include joint courses between the professions. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that common learning would be included at all stages of education, training and continuing professional development.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**62**	There should be more opportunities than at present for multi-professional teams to learn, train and develop together. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said more opportunities for multi-professional teams to train together were emerging as the common learning programme was rolled out.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**63**	All those preparing for a career in clinical care should receive some education in the management of healthcare, the health service and the skills required for management. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that education in management of healthcare and the health service, and development of the management skills	The Department of Health's Response to the BRI Inquiry, January 2002.	

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			required, were included and assessed in all professional curricula. The Department said it would continue to work with professional bodies and education institutions to ensure these areas received prominence.		
Improving NHS culture and governance	**64**	Greater opportunities should be created for managers and clinicians to 'shadow' one another for short periods to learn about their roles and work pressures. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that the NHS Leadership Centre would ensure that managers and clinicians had more opportunities to learn about their respective roles and work pressures through the Lifelong Learning programme.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**65**	An early priority for the new NHS Leadership Centre should be to offer guidelines as to the leadership styles and practices which are acceptable and to be encouraged within the NHS, and those which are not. (July 2001)	The Government agreed with this recommendation. The NHS Leadership Centre published the NHS Leadership Qualities Framework in 2002.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**66**	Steps should be taken to identify and train those within the NHS who have the potential to exercise leadership. There needs to be a sustained investment in developing leadership skills at all levels in the NHS. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that considerable investment in leadership development had been made and continued. By March 2002, 325 doctors were to have attended leadership programmes, and by November 2002, over 33,000 nurses and allied professionals.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Improving NHS culture and governance	**67**	The NHS's investment in developing and funding programmes in leadership skills should be focused on supporting joint education and multi-professional training, open to nurses, doctors, managers and other healthcare professionals. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to the new executive directors' development programme as focusing on multi-professional roles for medical and nursing directors.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**68**	The NHS Leadership Centre should be involved in all stages of the education, training and continuing development of all healthcare professionals. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that the NHS Leadership Centre would work alongside Workforce Confederations and Higher Education colleagues to influence curriculum planning.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**69**	Regulation of healthcare professionals is not just about disciplinary matters. It should be understood as encapsulating all of the systems which combine to assure the competence of healthcare professionals: education, registration, training, continuing professional development and revalidation as well as disciplinary matters. (July 2001)	The Government agreed with this recommendation in part. In its January 2002 response, the Department of Health said it recognised that regulatory bodies had expertise and specialisation in the field of education, training and development, and that the new Council for the Regulation of Healthcare Professionals should be able to ensure that a single overarching view was taken of the same. However, the Department said it did not agree that the new Council should be given powers to determine standards for education and admission to practice.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Improving NHS culture and governance **Regulation and oversight of NHS managers**	**70**	For each group of healthcare professionals (doctors, nurses and midwives, the professions allied to medicine, and managers) there should be one body charged with overseeing all aspects relating to the regulation of professional life: education, registration, training, continuing professional development, revalidation and discipline. The bodies should be: for doctors, the General Medical Council; for nurses and midwives, the new Nursing and Midwifery Council; for the professions allied to medicine, the re-formed professional body for those professions; and for senior healthcare managers, a new professional body. (July 2001)	The Government agreed with this recommendation in part. In its January 2002 response, the Department of Health said it did not agree that the General Medial Council should act as the competent authority for medical training. The Department did not address the recommendation for a new professional body for senior healthcare managers.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**71**	In addition, a single body should be charged with the overall coordination of the various professional bodies and with integrating the various systems of regulation. It should be called the Council for the Regulation of Healthcare Professionals. (In effect, this is the body currently proposed in 'The NHS Plan', and referred to as the Council of Healthcare Regulators.)	The Government agreed with this recommendation. The Health Professionals Council was set up in 2003, under the National Health Service Reform and Health Care Professions Act 2002.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**72**	The Council for the Regulation of Healthcare Professionals should be established as a matter of priority. It should have a statutory basis. It should report to Parliament. It should have a broadly-based membership, consisting of representatives of the bodies which regulate the various groups of	The Government agreed with this recommendation. In its January 2002 response, the Department of Health proposed that the Council should be accountable to Parliament, have 17 members drawn for the current	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		healthcare professionals, of the NHS, and of the general public. (July 2001)	regulatory bodies, patient & public representatives and NHS interests. The Health Professionals Council was set up in 2003, under the National Health Service Reform and Health Care Professions Act 2002.		
Improving NHS culture and governance	**73**	The Council for the Regulation of Healthcare Professionals should have formal powers to require bodies which regulate the separate groups of healthcare professionals to conform to principles of good regulation. It should act as a source of guidance and of good practice. It should seek to ensure that in practice the bodies which regulate healthcare professionals behave in a consistent and broadly similar manner. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said the Council would be expected to respect the independence of the regulatory bodies in exercising these powers to allow them the maximum opportunity to act voluntarily. The Health Professionals Council was set up in 2003, under the National Health Service Reform and Health Care Professions Act 2002.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**74**	It should be a priority for the Council for the Regulation of Healthcare Professionals to promote common curricula and shared learning across the professions. (July 2001)	The Government agreed in part with this recommendation. In its January 2002 response, the Department of Health said it recognised that regulatory bodies had expertise and specialisation in the field of education, training and development, and that the new Council for the Regulation of Healthcare Professionals should be able to ensure that a single overarching view was taken of the same. However, the Department said it did not agree that the new Council should be given powers to determine standards for education and admission to practice.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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	75	Pilot schemes should be established to develop and evaluate the feasibility of making the first year's course of undergraduate education common to all those wishing to become healthcare professionals. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it was piloting common learning undergraduate programmes and would ensure it developed and evaluated a range of workable approaches.	The Department of Health's Response to the BRI Inquiry, January 2002.	
	76	Universities should develop closer links between medical schools and schools of nursing education with a view to providing more joint education between medical and nursing students. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that universities were developing closer links with schools of nursing education.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**77**	Universities should develop closer links between medical and nursing schools and centres for education and training in health service and public sector management, with a view to enabling all healthcare professionals to learn about management. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that the NHS Leadership Centre would be working with medical and nursing schools to ensure management skills were developed within all curricula for healthcare professionals.	The Department of Health's Response to the BRI Inquiry, January 2002.	
	78	Access to medical schools should be widened to include people from diverse academic and socio-economic backgrounds. Those with qualifications in other areas of healthcare and those with an educational background in subjects other than science, who have the ability and wish to do so, should have greater opportunities than is presently the case, to enter medical schools. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that when medical schools were asked to bid for extra places in 2000 and 2001, they were asked to demonstrate an active commitment to recruiting students from a broad range of social, ethnic and educational backgrounds.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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	79	The attributes of a good doctor, as set down in the General Medical Council's 'Good Medical Practice', must inform every aspect of the selection criteria and curricula of medical schools. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to planned improvements in selection criteria and medical schools' curricula to help ensure doctors developed the necessary skills and attributes.	The Department of Health's Response to the BRI Inquiry, January 2002.	
	80	The NHS and the public should be involved in (a) establishing the criteria for selection and (b) the selection of those to be educated as doctors, nurses and as other healthcare professionals. (July 2001)	The Government agreed with this recommendation in principle. In its January 2002 response, the Department of Health said that all recruitment and admission procedures were based on published criteria to assist transparency and that it was committed to encouraging broad participation in selection procedures.	The Department of Health's Response to the BRI Inquiry, January 2002.	
	81	In relation to doctors, we endorse the proposal to establish a Medical Education Standards Board, to co-ordinate postgraduate medical training. The Medical Education Standards Board should be part of and answerable to the General Medical Council which should have a wider role. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said that post-graduate training needed to take into account the needs of the NHS as well as the needs of individual clinicians, meaning the Medical Education Standards Board needed to have closer links with the NHS.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**82**	Continuing professional development, being fundamental to the quality of care provided to patients, should be compulsory for all healthcare professionals. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it was already part of the duty of healthcare professionals to maintain their knowledge and skills and	The Department of Health's Response to the BRI Inquiry, January 2002.	

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			keep up to date, this forming part of the appraisal and revalidation process.		
Improving patient safety	**83**	Trusts and primary care trusts should provide incentives to encourage healthcare professionals to maintain and develop their skills. The contract (or, in the case of GPs, other relevant mechanism) between the trust and the healthcare professional should provide for the funding of continuing professional development and should stipulate the time which the trust will make available for continuing professional development. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said £20m was being invested to support implementation of appraisal and better access to continuing professional development. The Department said it was clear that all healthcare professionals should have a personal development plan; in the case of doctors such a plan would be required as part of appraisal.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**84**	Trusts and primary care trusts must take overall responsibility through an agreed plan for their employees' use of the time allocated to continuing professional development. They must seek to ensure that the resources deployed for continuing professional development contribute towards meeting the needs of the trust and of its patients, as well as meeting the professional aspirations of individual healthcare professionals. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it had made it clear continuing professional development requirements should be identified on the basis of the individual's needs, but in the context of the organisation's needs.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**85**	Periodic appraisal should be compulsory for all healthcare professionals. The requirement to participate in appraisal should be included in the contract of employment. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it had made it clear that appraisal would be introduced for all health professionals.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Improving patient safety	**86**	The commitment in 'The NHS Plan' to introduce regular appraisal for hospital consultants must be implemented as soon as possible. (July 2001)	The Government agreed with this recommendation. Consultant appraisal was introduced in April 2001.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**87**	The requirement to undergo periodic appraisal should also be incorporated into GP's terms of service. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that GP appraisal was under negotiation. GP appraisals were introduced later in 2002.	The Department of Health's Response to the BRI Inquiry, January 2002. GP Appraisals. Information about GP Appraisals | Patient	
Improving patient safety	**88**	Periodic revalidation, whereby healthcare professionals demonstrate that they remain fit to practise in their chosen profession, should be compulsory for all healthcare professionals. The requirement to participate in periodic revalidation should be included in the contract of employment. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it was working with the General Medical Council to introduce revalidation for all doctors and that it would work with other regulatory and professional bodies to ensure a consistent approach for all health professionals. Revalidation requirements for doctors were not introduced by the General Medical Council until December 2012. Revalidation requirements for nurses were not introduced until April 2016.	The Department of Health's Response to the BRI Inquiry, January 2002. Revalidation - Current State of Play. Revalidation Process. | Patient Revalidation celebrates one year anniversary - The Nursing and Midwifery Council	

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Improving patient safety	**89**	The public, as well as the employer and the relevant professional group, must be involved in the processes of revalidation. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that medical revalidation would involve lay people participating in local panels, and that this model would provide a benchmark for other professions. The proposal to evaluate doctors by revalidation panels was dropped by April 2003.	The Department of Health's Response to the BRI Inquiry, January 2002. Revalidation in the UK - PMC (nih.gov)	
Improving patient safety	**90**	The new Council for the Regulation of Healthcare Professionals should take as a further priority an early review of the various systems of revalidation and re-registration to ensure that they are sufficiently rigorous, and in alignment both with each other and with other initiatives to protect the public. The Council should also seek ways to incorporate managers (as healthcare professionals) into the systems of continuing professional development, appraisal and revalidation. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said the Council would have a critical role in ensuring consistency across the regulatory bodies. The Department said it would develop a code of conduct for senior managers, which was later published in October 2002.	The Department of Health's Response to the BRI Inquiry, January 2002. Code of Conduct for NHS Managers: October 2002 Department of Health	
Regulation and oversight of NHS managers	**91**	Managers as healthcare professionals should be subject to the same obligations as other healthcare professionals, including being subject to a regulatory body and professional code of practice. (July 2001)	The Government agreed in part with this recommendation. In its January 2002 response, the Department of Health said it did not think it practicable to establish self-regulation for senior managers. The Department agreed that the standards expected of senior managers should be explicit, and it favoured a code of conduct, stronger performance management and tighter contracts.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Improving NHS culture and governance	**92**	Where clinicians hold managerial roles which extend beyond their immediate clinical practice, sufficient protected time in the form of allocated sessions must be made available for them to carry out that managerial role. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that under its proposals for a new consultant contract, consultant's job plans would specifically address the time commitments needed for managerial duties.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Regulation and oversight of NHS managers	**93**	Any clinician, before appointment to a managerial role, must demonstrate the managerial competence to undertake what is required in that role: training and support should be made available by trusts and primary care trusts. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that clinical director and medical director development programmes would be rolled out from January 2002.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Regulation and oversight of NHS managers	**94**	Clinicians should not be required or expected to hold managerial roles on bases other than competence for the job. For example, seniority or being next in turn are not appropriate criteria for the appointment of clinicians to managerial roles. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to the development of the NHS Leadership Qualities Framework, which was published by the NHS Leadership Centre later in 2002. The Department said this would be applied to clinicians moving into managerial roles.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Regulation and oversight of NHS managers	**95**	The professional and financial incentives for senior clinicians to undertake full-time senior managerial roles should be reviewed: the aim should be to enable senior clinicians to move into a full-time managerial role, and subsequently, if they so wish, to move back into clinical practice after appropriate retraining and revalidation. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that revalidation together with appraisal and better systems for professional development would make it easier to move between clinical and managerial roles.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Regulation and oversight of NHS managers	**96**	To protect patients, in the case of clinicians who take on managerial roles but wish to continue to practise as clinicians, experts together with managers from the NHS should issue advice as to the minimum level of regular clinical practice necessary to enable a clinician to provide care of a good quality. Clinicians not maintaining this level of practice should not be entitled to offer clinical care. This rule should also apply to all other clinicians who, for whatever reason, are not in full-time practice, and not only to those in part-time managerial roles. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said it did not believe it possible to prescribe a minimum level of regular clinical practice to suit all specialties.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Regulation and oversight of NHS managers	**97**	To facilitate the movement of clinicians in and out of managerial positions, the proposed systems for the revalidation (and re-registration) of doctors, nurses and professions allied to medicine should distinguish between professionals who are managers and also maintaining a clinical practice and those who are not. Those who are not maintaining a clinical practice should be entitled to obtain the appropriate revalidation (and re-registration to restart a clinical practice), after retraining, and should be assisted in doing so. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said it did not believe it possible to prescribe a minimum level of regular clinical practice to suit all specialties. When revalidating or re-registering, health professionals would need to provide evidence they were competent to practice, with advisory and support services available as part of the appraisal process for those outside substantive employment. Revalidation requirements for doctors were not introduced by the General Medical Council until December 2012. Revalidation requirements for nurses were not introduced until April 2016.	The Department of Health's Response to the BRI Inquiry, January 2002. Revalidation - Current State of Play. Revalidation Process. | Patient Revalidation celebrates one year anniversary - The Nursing and Midwifery Council	

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Regulation and oversight of NHS managers	**98**	The relevant professional regulatory bodies should make rules varying the professional duties of those professionals, whose registration they hold, who are in full-time managerial roles, so as to take account of the fact that, while occupying such roles, they do not undertake responsibility for the care of patients. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said that most health professionals, even those in full-time management roles, needed to retain their professional status, and that it would not be helpful to patients if registration status was subject to periodic changes.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**99**	Any clinician carrying out any clinical procedure for the first time must be directly supervised by colleagues who have the necessary skill, competence and experience until such time as the relevant degree of expertise has been acquired. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that job plans for consultants included responsibility for the supervision of their staff as well as for themselves when carrying out procedures for the first time. The Department referred to the appraisal process for consultants as identifying professional development needs.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**100**	Before any new and hitherto untried invasive clinical procedure can be undertaken for the first time, the clinician involved should have to satisfy the relevant local research ethics committee that the procedure is justified and it is in the patient's interests to proceed. Each trust should have in place a system for ensuring that this process is complied with. (July 2001)	The Government agreed in principle with this recommendation. In its January 2002 response, the Department of Health said that new interventional procedures would need to be overseen and scrutinised by the National Institute for Clinical Excellence from April 2002 and local research ethics committees would need to consider any studies of new procedures as advised by the National Institute for Clinical Excellence. The Department said guidance on the new arrangements would specify local systems for managing new interventional procedures and would be issued in 2002.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Improving patient safety	**101**	Local research ethics committees should be re-formed as necessary so that they are capable of considering applications to undertake new and hitherto untried invasive clinical procedures. (July 2001)	The Government agreed in principle with this recommendation. In its January 2002 response, the Department of Health said that new interventional procedures would need to be overseen and scrutinised by the National Institute for Clinical Excellence from April 2002 and local research ethics committees would need to consider any studies of new procedures as advised by the National Institute for Clinical Excellence. The Department said guidance on the new arrangements would specify local systems for managing new interventional procedures and would be issued in 2002.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**102**	Patients are always entitled to know the extent to which a procedure which they are about to undergo is innovative or experimental. They are also entitled to be informed about the experience of the clinician who is to carry out the procedure. (July 2001)	The Government agreed in principle with this recommendation. In its January 2002 response, the Department of Health said that guidance to be issued in 2002 would make clear the information clinicians must give to patients about new procedures, including their own experience and how further information could be accessed.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**103**	The Royal College of Surgeons of England should, in partnership with university medical schools and the NHS, be enabled to develop its unit for the training of surgeons, particularly in new techniques. It should also explore the question of whether there is an age beyond which surgeons, specifically in areas such as paediatric cardiac surgery, should	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it would review the need for further development of the Royal College of Surgeons' training unit. The Department said it had asked the Paediatric and Congenital Cardiac Services Review Group to consider age limits for surgeons	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		not attempt new procedures or even should not continue in a particular field of surgery. (July 2001)	undertaking paediatric cardiac surgery, and it would then consider this for other specialties and new procedures.		
Improving patient safety	**104**	In the exercise of their disciplinary function the professional regulatory bodies must adopt a more flexible approach towards what constitutes misconduct. They must deal with cases, as far as possible, at a local level and must have available a range of actions which both serve the interests of the public and the needs of the professional. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that disciplinary matters were best dealt with at local level, for which it would provide guidance. The Department referred to the establishment of the National Clinical Assessment Authority to provide support and advice to trusts and health authorities in dealing with doctors whose performance gives rise to concerns, with it being able to make an assessment of the doctor and to recommend an appropriate course of action where local action fails to resolve the problem.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**105**	The need to involve the public in the various professional regulatory bodies applies as much to discipline as to all the other activities of these bodies. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to proposals for the new Nursing and Midwifery and Health Professions Council to include strong input to police and casework, and proposals for General Medical Council reform envisaging greater public involvement.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**106**	We support and endorse the broad framework of recommendations advocated in the report ' An Organisation with a Memory' by the Chief Medical Officer's expert group on learning from adverse events in the NHS. The National Patient Safety Agency proposed as a consequence of that report should, like all other bodies which contribute to the	The Government rejected the recommendation that the National Patient Safety Agency be outwith the NHS. In its January 2002 response, the Department of Health said the organisation had been established in 2001 as a	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		regulation of the safety and quality of healthcare, be independent of the NHS and the Department of Health. (July 2001)	special health authority, ensuring it had the confidence of healthcare staff and was able to work closely with the NHS.		
Improving NHS culture and governance **Improving the ability to raise complaints and concerns**	**107**	Every effort should be made to create in the NHS an open and non-punitive environment in which it is safe to report and admit sentinel events. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to the work of the National Patient Safety Agency with the clinical governance initiative and the Department's Risk Management System as aiming to develop a culture where non-punitive reporting of adverse incidents would help to improve patient safety.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**108**	Major studies should, as a matter of priority, be carried out to investigate the extent and type of sentinel events in the NHS to establish a baseline against which improvements can be made and measured. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that the National Patient Safety Agency was piloting a system for establishing a national database of adverse incidents and near misses to provide a baseline against which future improvements could be judged.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving the ability to raise complaints and concerns	**109**	There should a single, unified, accessible system for reporting and analysing sentinel events, with clear protocols indicating the categories of information which must be reported to a national database. (July 2001)	The Government agreed with this recommendation. The National Reporting and Learning System was set up in 2003.	The Department of Health's Response to the BRI Inquiry, January 2002. NRLS Reporting	

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Improving patient safety	**110**	The national database of sentinel events should be managed by the National Patient Safety Agency, so as to ensure that a high degree of confidence is placed in the system by the public. (July 2001)	The Government agreed with this recommendation. The National Reporting and Learning System was set up in 2003 and at the time managed by the National Patient Safety Agency. The System was subsequently transferred to NHS England in June 2012.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**111**	The National Patient Safety Agency, in the exercise of its function of surveillance of sentinel events, should be required to inform all trusts of the need for immediate action, in the light of occurrences reported to it. The Agency should also be required to publish regular reports on patterns of sentinel events and proposed remedial actions. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said guidance would make clear the appropriate local action needed in respect of any adverse incident reported to the National Patient Safety Agency, and that the Agency would publish regular reports on trends and patterns and disseminate guidance on lessons learned.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**112**	All sentinel events should be subject to a form of structured analysis in the trust where they occur, which takes into account not only the conduct of individuals, but also the wider contributing factors within the organisation which may have given rise to the event. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said this was already a requirement of its Risk Management System and would be reinforced by root cause analysis of serious incidents. The Department said the National Patient Safety Agency would issue guidance.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving the ability to raise complaints and concerns	**113**	The reporting of sentinel events must be made as easy as possible, using all available means of communication (including a confidential telephone reporting line). (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that its aim was for most reports of adverse incidents to the National Patient Safety Agency to be transmitted	The Department of Health's Response to the BRI Inquiry, January 2002.	

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			electronically and that a confidential telephone line would also be established.		
Improving the ability to raise complaints and concerns	**114**	Members of staff in the NHS should receive immunity from disciplinary action by the employer or by a professional body if they report a sentinel event to the trust or to the national database within 48 hours, except where they themselves have committed a criminal offence. (July 2001)	In its January 2002 response, the Department of Health said it agreed in principle with this recommendation. The Department said it would explore, through the work of the Chief Medical Officer's Committee on Clinical Negligence, how this could be introduced.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**115**	Members of staff in the NHS who cover up or do not report a sentinel event may be subject to disciplinary action by their employer or by their professional body. (July 2001)	In its January 2002 response, the Department of Health said it agreed in principle with this recommendation. The Department said it would explore, through the work of the Chief Medical Officer's Committee on Clinical Negligence, how this could be introduced.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving the ability to raise complaints and concerns	**116**	The opportunity should exist to report a sentinel event in confidence. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said information reported to the National Patient Safety Agency would be held in confidence.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving the ability to raise complaints and concerns	**117**	There should be a stipulation in every healthcare professional's contract that sentinel events must be reported, that reporting can be confidential, and that reporting within a specified time period will not attract disciplinary action. (July 2001)	In its January 2002 response, the Department of Health said it agreed in principle with this recommendation, unless a criminal offence had been committed. The Department said it would explore, through the work of the Chief Medical Officer's Committee on Clinical Negligence, how this could be introduced.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Improving the ability to raise complaints and concerns	**118**	The process of reporting of sentinel events should be integrated into every trust's internal communications, induction training and other staff training. Staff must know what is expected of them, to whom to report and what systems are in place to enable them to report. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said this would be included in revised guidance on its Risk Management System and guidance from the National Patient Safety Agency.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving the ability to raise complaints and concerns **Improving NHS culture and governance**	**119**	In order to remove the disincentive to open reporting and the discussion of sentinel events represented by the clinical negligence system, this system should be abolished. It should be replaced by an alternative system for compensating those patients who suffer harm arising out of treatment from the NHS. An expert group should be established to advise on the appropriate method of compensation to be adopted. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it had announced plans to produce a White Paper early in 2002, discussing options for reform to the system for dealing with clinical negligence claims. A report was published by the Department of Health in July 2003, setting out proposals for reforming the approach to clinical negligence in the NHS. The NHS Redress Act 2006, containing provisions for the establishment of a redress scheme outside the scope of civil proceedings, was enacted but never brought into force.	The Department of Health's Response to the BRI Inquiry, January 2002. Making amends: a consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS : Department of Health, July 2003 NHS Redress Act 2006.	
Improving patient safety	**120**	The proposed National Patient Safety Agency should, as a matter of urgency, bring together managers in the NHS, representatives of the pharmaceutical companies and manufacturers of medical equipment, members of the healthcare professions and the public, to seek to apply	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it was working with the Design Council to look at ways	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		approaches based on engineering and design so as to reduce (and eliminate to the extent possible) the incidence of sentinel events. (July 2001)	of improving patient safety through new engineering and design solutions.		
Improving NHS culture and governance	**121**	At the level of individual trusts, an executive member of the board should have the responsibility for putting into operation the trust's strategy and policy on safety in clinical care. Further, a non-executive director should be given specific responsibility for providing leadership to the strategy and policy aimed at securing safety in clinical care. (July 2001)	The Government agreed in part with this recommendation. In its January 2002 response, the Department of Health said it believed safety should be the responsibility of the whole board. The Department said it would issue guidance requiring each trust board to designate a non-executive director to provide leadership.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**122**	One body should be responsible for co-ordinating all action relating to the setting, issuing and keeping under review of national clinical standards: this should be the National Institute for Clinical Excellence, suitably structured so as to give it the necessary independence and authority. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said that while the National Institute for Clinical Excellence was the foremost body in providing clinical guidelines and technology appraisals, other bodies were still best placed to set standards in their fields.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**123**	Once the recommended system is in place, only the National Institute for Clinical Excellence should be permitted to issue national clinical standards to the NHS. The Department of Health (as the headquarters of the NHS) while issuing, for example, National Service Frameworks and supplementary guidance, should not be able to rescind or detract from the standards issued by the	The Government rejected this recommendation. In its January 2002 response, the Department of Health said that while the National Institute for Clinical Excellence was the foremost body in providing clinical guidelines and technology appraisals, other bodies were still best placed to set standards in their fields.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		National Institute for Clinical Excellence. (July 2001)			
Improving patient safety	**124**	The National Institute for Clinical Excellence should pursue vigorously its current policy of involving as wide a community as possible, including the public, patients and carers, in the work to develop and keep under review clinical standards. In particular, the special expertise of the Royal Colleges and specialist professional associations should be harnessed and supported. Account should also be taken of the expertise of the senior management of the NHS. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said the National Institute for Clinical Excellence actively involved a range of stakeholders via 6 national collaborating centres and a special unit to help patients and carers who wished to participate in developing guidelines, as well as seeking comments from NHS bodies on its draft recommendations.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**125**	National standards of clinical care should reflect the commitment to patient-centred care and thus in future be formulated from the perspective of the patient. The standards should address the quality of care that a patient with a given illness or condition is entitled to expect to receive from the NHS. The standards should take account of the best available evidence. The standards should include guidance on how promptly patients should get access to care. They should address the roles and responsibilities of the various healthcare professionals who will care for the patient. They should take account of the patient's journey from primary care, into the hospital system (if necessary), and back to primary and community care, and of the necessary facilities and equipment. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that National Institute for Clinical Excellence guidelines were developed to ensure that clinical standards were focused on the patient, with special versions of guidance written for patients and carers.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Improving patient safety	**126**	Such standards for clinical care as are established should distinguish clearly between those which are obligatory and must be observed, and those to which the NHS should aspire over time. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said that where National Institute for Clinical Excellence guidance existed it would become the standard. Advice from professional bodies which went beyond National Institute for Clinical Excellence guidance could be regarded as aspirational.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**127**	A timetable over the short, medium and long term should be published, and revised periodically, for the development of national clinical standards, so that the public may be consulted and kept aware of those areas of healthcare which are covered by such standards and those which will be covered in the future. Target dates should be set by which clinical standards will have been prepared for all major conditions and illnesses. (July 2001)	The Government agreed in principle with this recommendation. In its January 2002 response, the Department of Health said that the National Institute for Clinical Excellence already published a timetable for the production of its standards on its website, and that the Department would publish a consultation document covering the detail of the process of topic selection for the National Institute for Clinical Excellence.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**128**	Resources, and any necessary statutory authority, must be made available to the National Institute for Clinical Excellence to allow it to perform its role of developing, issuing and keeping under review national clinical standards. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that funding for the National Institute for Clinical Excellence had grown in line with its increasing activity.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**129**	Standards of clinical care which patients are entitled to expect to receive in the NHS should be made public. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that the National Institute for Clinical Excellence	The Department of Health's Response to the BRI Inquiry, January 2002.	

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			already published its guidance and produced versions tailored to patients' and carers' needs.		
Improving patient safety	**130**	There must be a single, coherent, co-ordinated set of generic standards: that is, standards relating to the patient's experience and the systems for ensuring that care is safe and of good quality (for example corporate management, clinical governance, risk management, clinical audit, the management and support of staff, and the management of resources). Trusts must comply with these standards. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that clinical governance already provided a comprehensive framework against which trusts' services could be judged and, in addition, all trusts were required by the Treasury to maintain effective systems of financial, organisational and clinical controls.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**131**	The current system of inspection of trusts and primary care trusts should be changed to become a system of validation and periodic revalidation of these trusts. The system should be supportive and flexible. Its aim should be to promote continued improvement in the quality of care. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said it believed that the proposed system of validation and revalidation could have a detrimental effect on the delivery of health services. The Department proposed instead that the Commission for Health Improvement have the power and responsibility to recommend special measures for trusts which failed to meet standards.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**132**	One body should be responsible for validating and re-validating NHS trusts and primary care trusts. This body should be the Commission for Health Improvement, suitably structured so as to give it the necessary independence and authority. Other bodies (for example the NHS Litigation Authority) which are currently concerned with setting and requiring compliance with those generic standards	The Government rejected this recommendation. In its January 2002 response, the Department of Health said it believed that the proposed system of validation and revalidation could have a detrimental effect on the delivery of health services. The Department proposed instead to give the Commission for Health Improvement the power	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		which should fall within the authority of Commission for Health Improvement, should carry out their role in this respect under the authority of and answerable to the Commission for Health Improvement. (July 2001)	and responsibility to recommend special measures for trusts which failed to meet standards.		
Improving NHS culture and governance	**133**	Validation and revalidation of trusts should be based upon compliance with the generic standards which relate to the patient's experience and the systems for ensuring that care is safe and of good quality. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said it believed that the proposed system of validation and revalidation could have a detrimental effect on the delivery of health services. The Department proposed instead to give the Commission for Health Improvement the power and responsibility to recommend special measures for trusts which failed to meet standards.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**134**	The standards against which trusts are to be validated, and the results of the process of validation or revalidation, should be made public. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said it believed that the proposed system of validation and revalidation could have a detrimental effect on the delivery of health services. The Department proposed instead to give the Commission for Health Improvement the power and responsibility to recommend special measures for trusts which failed to meet standards.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**135**	Any organisation in the voluntary or private sector which provides services to NHS patients should be required to meet the standards for systems, facilities and staff which organisations in the NHS must meet. The aim should be that, wherever care	The Government rejected this recommendation. In its January 2002 response, the Department of Health said it believed that the proposed system of validation and revalidation could have a detrimental effect on the delivery	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		is funded by the NHS, there is a single system of validation which indicates to the public that the organisation meets the necessary standards. (July 2001)	of health services. The Department proposed instead to give the Commission for Health Improvement the power and responsibility to recommend special measures for trusts which failed to meet standards.		
Improving NHS culture and governance	**136**	The validating body should have the power to withdraw, withhold or suspend a trust's validation if standards fall such as to threaten the quality of care or the safety of patients. Any trust or organisation whose validation may be affected in this way must be given the opportunity to take appropriate remedial action. It must then satisfy the Commission for Health Improvement that it has taken remedial action before its continued validation can be confirmed. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said it believed that the proposed system of validation and revalidation could have a detrimental effect on the delivery of health services. The Department proposed instead to give the Commission for Health Improvement the power and responsibility to recommend special measures for trusts which failed to meet standards.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**137**	The Commission for Health Improvement should consider how it might work with the providers of those programmes of accreditation already adopted by a significant number of trusts. In the future, where required standards are met, the Commission for Health Improvement should accept as part of its validation process the accreditation obtained through these programmes. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said it believed that the proposed system of validation and revalidation could have a detrimental effect on the delivery of health services. The Department proposed instead to give the Commission for Health Improvement the power and responsibility to recommend special measures for trusts which failed to meet standards.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**138**	The process of validation of trusts should, in time, be extended to cover discrete, identifiable services within trusts. This extension of validation should first be piloted and evaluated. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said it believed that the proposed system of validation and revalidation could have a detrimental effect on the delivery	The Department of Health's Response to the BRI Inquiry, January 2002.	

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			of health services. The Department proposed instead to give the Commission for Health Improvement the power and responsibility to recommend special measures for trusts which failed to meet standards.		
Improving NHS culture and governance	**139**	The pilot exercise for this form of validation should include children's acute hospital services and paediatric cardiac surgery. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said it believed that the proposed system of validation and revalidation could have a detrimental effect on the delivery of health services. The Department proposed instead to give the Commission for Health Improvement the power and responsibility to recommend special measures for trusts which failed to meet standards.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**140**	Should the pilot exercise be successful, the category of discrete services which should be a priority for this form of validation are those specialist services which are currently funded or meet the criteria for funding by the National Specialist Commissioning Group (the successor to the Supra Regional Services Advisory Group). (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health said it believed that the proposed system of validation and revalidation could have a detrimental effect on the delivery of health services. The Department proposed instead to give the Commission for Health Improvement the power and responsibility to recommend special measures for trusts which failed to meet standards.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**141**	For discrete services, whether specialist services or otherwise, to be validated trusts they must be able to demonstrate that all relevant aspects of the service can currently be met, rather than that the trust aims to develop so as to be able to do so at some point in the future. Trusts which do not meet	The Government rejected this recommendation. In its January 2002 response, the Department of Health said it believed that the proposed system of validation and revalidation could have a detrimental effect on the delivery of health services. The Department proposed instead to	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		the necessary standards to ensure the safety of patients and a good quality of care should not be permitted to offer, or continue to offer, the relevant service. (July 2001)	give the Commission for Health Improvement the power and responsibility to recommend special measures for trusts which failed to meet standards.		
Improving NHS culture and governance	**142**	Where the interests of securing quality of care and the safety of patients require that there be only a small number of centres offering a specialist service, the requirements of quality and safety should prevail over considerations of ease of access. It is and should be the responsibility of the NHS to assist patients, and their families or carers, with the cost of transport and accommodation when they have to travel away from home to receive specialist services. Such support should not be the subject of a means test. (July 2001)	In its January 2002 response, the Department of Health rejected the proposal to extend the hospital travel costs scheme, but said it would encourage trusts to use their discretionary powers to support families visiting relatives, including children.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**143**	The process of clinical audit, which is now widely practised within trusts, should be at the core of a system of local monitoring of performance. Clinical audit should be multidisciplinary. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said multi-disciplinary audit was already a key feature of clinical governance.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**144**	Clinical audit must be fully supported by trusts. They should ensure that healthcare professionals have access to the necessary time, facilities, advice and expertise in order to conduct audit effectively. All trusts should have a central clinical audit office which co-ordinates audit activity, provides advice and support for the audit process, and brings	The Government agreed in principle with this recommendation. In its January 2002 response, the Department of Health said that each trust had a lead individual with responsibility for clinical audit and all doctors were required to participate in clinical audit programmes. The Department considered it	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		together the results of audit for the trust as a whole. (July 2001)	was for individual trusts to decide how clinical audit activity should be supported locally.		
Improving patient safety	**145**	Clinical audit should be compulsory for all healthcare professionals providing clinical care and the requirement to participate in it should be included as part of the contract of employment. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said this was being addressed for doctors through the introduction of appraisal as a contractual requirement and the impending introduction of General Medical Council revalidation. In fact, revalidation requirements for doctors were not introduced by the General Medical Council until December 2012.	The Department of Health's Response to the BRI Inquiry, January 2002. Revalidation - Current State of Play. Revalidation Process. | Patient	
Improving NHS culture and governance	**146**	The monitoring of clinical performance at a national level should be brought together and co-ordinated in one body: an independent Office for Information on Healthcare Performance. This Office should be part of the Commission for Health Improvement. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said proposals for an independent Office for Information On Health Care Performance within the Commission for Health Improvement were included in the NHS and Health Care Professionals Bill, with the Office to collect, analyse and publish reports on clinical and other NHS data. The Office for Information On Health Care Performance was created in 2003 under the National Health Service Reform and Health Care Professions Act 2002. .	The Department of Health's Response to the BRI Inquiry, January 2002. National Health Service Reform and Health Care Professions Act 2002	

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Improving NHS culture and governance	**147**	The Office for Information on Healthcare Performance should supplant the current fragmentation of approach through a programme of activities involving the co-ordination of the various national audits. In addition to its other responsibilities, the new system should provide a mechanism for surveillance whereby patterns of performance in the NHS which may warrant further scrutiny can be identified as early as possible. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said the Office for Information on Health Care Performance would undertake this task as part of its key functions.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**148**	The current 'dual' system of collecting data in the NHS in separate administrative and multiple clinical systems is wasteful and anachronistic. A single approach to collecting data should be adopted, which clinicians can trust and use and from which information about both clinical and administrative performance can be derived. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that those responsible for the separate administrative and clinical audit databases were working together to develop an approach which would avoid duplication.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**149**	Steps should be taken nationally and locally to build the confidence of clinicians in the data recorded in the Patient Administration Systems in trusts (which is subsequently aggregated nationally to form the Hospital Episode Statistics). Such steps should include the establishment by trusts of closer working arrangements between clinicians and clinical coding staff. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that a number of steps had been taken to engage clinicians with the value of the data recorded in the Patient Administration System and Hospital Episode Statistics, including major consultation on performance indicators and discussions with the British Medical Association about how Hospital Episode Statistics data could be used to monitor clinical quality.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Improving patient safety	**150**	The Hospital Episode Statistics database should be supported as a major national resource which can be used reliably, with care, to undertake the monitoring of a range of healthcare outcomes. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that its investment included work on a new contract and tendering the service for supplying Hospital Episode Statistics data, which would deliver improvements in service and create the opportunity to extend the database.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**151**	Systems for clinical audit and for monitoring performance rely on accurate and complete data. Competent staff, trained in clinical coding, and supported in their work are required: the status, training and professional qualifications of clinical coding staff should be improved. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that a re-evaluation of the training infrastructure for clinical coders would commence in 2002, to lead to range of measures to improve their training and career structure.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**152**	The system of incentives and penalties to encourage trusts to provide complete and validated data of a high quality to the national database should be reviewed. Any new system must include reports of each trust's performance in terms of the quality and timeliness of the submission of data. The systems within a trust for producing data of a high quality, and its performance in returning such data in a timely manner to the national database, should be taken into account in the process of validating and revalidating the trust. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it would include a data quality indicator in the annual NHS performance indicators. The Department said that the Commission for Health Improvement had been looking at the quality of data available to trusts in its reviews of clinical governance, and the NHS Information Authority had been commissioned to develop a data quality strategy to support the NHS modernisation agenda by September 2002.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**153**	At national level, the indicators of performance should be comprehensible to the public as well as to healthcare professionals. They should be fewer	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it had undertaken a wide-ranging consultation with the	The Department of Health's Response	

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		and of high quality, rather than numerous but of questionable or variable quality. (July 2001)	NHS and public on which performance indicators should be published, and in September 2001 published 6 high level indicators against which acute trusts were rated.	to the BRI Inquiry, January 2002.	
Improving patient safety	**154**	The need to invest in world-class IT systems must be recognised so that the fundamental principles of data collection, validation and management can be observed: that data be collected only once; that the data be part and parcel of systems used to support healthcare professionals in their care of patients; and that trusts and the teams of healthcare professionals receive feedback when data on their services are aggregated. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it was investing in its Information for Health Strategy, with electronic patient records to be available by 2005.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**155**	Patients and the public must be able to obtain information as to the relative performance of the trust and the services and consultant units within the trust. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that performance indicators for each trust would be published soon and the Office for Information on Health Care Performance would publish independent information on NHS performance once established. The Department said that further development work was needed before information could be published on services and particular specialities.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**156**	As part of their Annual Reports, trust boards should be required to report on the extent of their compliance with the national clinical standards. These reports should be made public and be made	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that trusts were already required annually to produce clinical guidance reports and to report progress in implementing National Service Frameworks and National	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		available to the Commission for Health Improvement. (July 2001)	Institute for Clinical Excellence guidelines, with these reports being public and available to the Commission for Health Improvement.		
Improving NHS culture and governance	**157**	The involvement of the public in the NHS must be embedded in its structures: the perspectives of patients and of the public must he heard and taken into account wherever decisions affecting the provision of healthcare are made. (July 2001)	The Government agreed with this recommendation. The National Health Service Reform and Health Care Professions Act 2002 established Patients' Forums and the Commission for Patient and Public Involvement in Health.	The Department of Health's Response to the BRI Inquiry, January 2002. National Health Service Reform and Health Care Professions Act 2002	
Improving NHS culture and governance	**158**	Organisations which are not part of the NHS but have an impact on it, such as Royal Colleges, the General Medical Council, the Nursing and Midwifery Council and the body responsible for regulating the professions allied to medicine, must involve the public in their decision-making processes, as they affect the provision of healthcare by the NHS. (July 2001)	The Government agreed in principle with this recommendation. In its January 2002 response, the Department of Health said that Royal Colleges and other professional bodies were moving towards greater public involvement.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**159**	The processes for involving patients and the public in organisations in the NHS must be transparent and open to scrutiny: the annual report of every organisation in the NHS should include a section setting out how the public has been involved, and the effect of that involvement. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to the annual Patient Prospectus, to be published by every acute trust from 2003, as demonstrating public involvement and its effect.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Improving NHS culture and governance	**160**	The public's involvement in the NHS should particularly be focused on the development and planning of healthcare services and on the operation and delivery of healthcare services, including the regulation of safety and quality, the competence of healthcare professionals, and the protection of vulnerable groups. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health referred to the Health and Social Care Act 2001 as placing a duty on NHS bodies to involve the public in the planning and operation of health care services.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**161**	Proposals to establish Patients' Forums and Patients' Councils must allow for the involvement of the wider public and not be limited only to patients or to patients' groups. They must be seen as an addition to the process of involving patients and the public in the activities of the NHS, rather than as a substitute for it. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it considered Patients' Forums would ensure that the public were able to become involved in NHS decisions.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**162**	The mechanisms for the involvement of the public in the NHS should be routinely evaluated. These mechanisms should draw on the evidence of what works. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health proposed that the Commission for Patient and Public Involvement in Health would identify and disseminate standards for the establishment, operation and evaluation of patient and public involvement and would submit regular reports to the Secretary of State. The National Health Service Reform and Health Care Professions Act 2002 established the Commission for Patient and Public Involvement in Health.	The Department of Health's Response to the BRI Inquiry, January 2002. National Health Service Reform and Health Care Professions Act 2002	

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Improving NHS culture and governance	**163**	The process of public involvement must be properly supported, through for example, the provision of training and guidance. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health proposed that the Commission for Patient and Public Involvement in Health would support patient and public involvement by setting standards, providing training and monitoring services from the patients' perspective. The National Health Service Reform and Health Care Professions Act 2002 established the Commission for Patient and Public Involvement in Health.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**164**	Financial resources must be made available to enable members of the public to become involved in NHS organisations: this should include provision for payments to cover, for example, the costs of childcare, or loss of earnings. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said expenses would be paid those who volunteered for Patients' Forums, Patient Advocacy and Liaison Service and the Commission for Patient and Public Involvement in Health.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**165**	The involvement of the public, particularly of patients, should not be limited to the representatives of patients' groups, or to those representing the interests of patients with a particular illness or condition: the NHS Modernisation Agency should advise the NHS on how to achieve the widest possible involvement of patients and the public in the NHS at local level. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that a national citizen leadership programme had been initiated to support patient representative organisations and the Patient Advocacy and Liaison Service.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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Improving NHS culture and governance	**166**	Primary care trusts (and groups), given their capacity to influence the quality of care in hospitals, must involve patients and the public, for example through each primary care trust's Patient Advocacy and Liaison Service. They must make efforts systematically to gather views and feedback from patients. They must pay particular attention to involving their local community in decision-making about the commissioning of hospital services. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health proposed that Patients' Forums should apply equally to primary healthcare and to secondary care.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**167**	A National Director for Children's Healthcare Services should be appointed to promote improvements in healthcare services provided for children. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said a National Clinical Director for Children was appointed in July 2001.	The Department of Health's Response to the BRI Inquiry, January 2002.	
	168	Consideration should be given to the creation of an office of Children's Commissioner in England, with the role of promoting the rights of children in all areas of public policy and seeking improvements to the ways in which the needs of children are met. Healthcare would be one of the areas covered by such a commissioner. Were such an office to be created, we would see it as being in addition to, rather than in place of, our other recommendations about the need to improve the quality of leadership in children's healthcare services. (July 2001)	The Office of the Children's Commissioner in England was established in 2005 under the Children Act 2004.	The Department of Health's Response to the BRI Inquiry, January 2002. Children Act 2004	
	169	The Cabinet Committee on Children and Young People's Services should specifically include in its	The Government rejected this recommendation.	The Department of Health's Response	

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		remit matters to do with healthcare and health services for children and young people. (July 2001)	In its January 2002 response, the Department of Health said it did not propose to change the remit of the Committee because it could and did consider health matters where appropriate.	to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**170**	Each health authority and each primary care group or primary care trust should designate a senior member of staff who should have responsibility for commissioning children's healthcare services locally. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that, as new structures were developed during 2002, each primary care group and primary care trust would ensure that a senior member of staff had designated responsibility for commissioning children's services.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**171**	All trusts which provide services for children as well as adults, should have a designated executive member of the board whose responsibility it is to ensure that the interests of children are protected and that they are cared for in a paediatric environment by paediatrically trained staff. (July 2001)	The Government agreed in principle with this recommendation. In its January 2002 response, the Department of Health said it would consider how best to take this forward as existing NHS structures were replaced.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**172**	The proposed National Service Framework for children's healthcare services must be agreed and implemented as a matter of urgency. (July 2001)	The Government agreed with this recommendation. The National Service Framework for Children: Standard for Hospital Services was published in April 2003. The full National Service Framework for Children, Young People and Maternity Services was published in October 2004.	The Department of Health's Response to the BRI Inquiry, January 2002. National Service Framework for Children Standard for Hospital	

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				Services, April 2003. National service framework: children, young people and maternity services (2004)	
Improving NHS culture and governance	**173**	The National Service Framework should include a programme for the establishment of standards in all areas of children's acute hospital and healthcare services. (July 2001)	The Government agreed with this recommendation. The National Service Framework for Children: Standard for Hospital Services was published in April 2003.	The Department of Health's Response to the BRI Inquiry, January 2002. National Service Framework for Children Standard for Hospital Services, April 2003.	
Improving NHS culture and governance	**174**	The National Service Framework should set obligatory standards which must be observed, as well as standards to which children's services should aspire over time. (July 2001)	The Government agreed with this recommendation. The National Service Framework for Children, Young People and Maternity Services included standards as well as long-term visions of outcomes.	The Department of Health's Response to the BRI Inquiry, January 2002. National service framework: children, young people and	

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				maternity services (2004)	
Improving NHS culture and governance	**175**	The National Service Framework should include incentives for the improvement of children's healthcare services, with particular help being given to those trusts most in need. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said incentives for the improvement of care would be part of the 'earned autonomy' programme for the NHS.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**176**	The National Service Framework must include plans for the regular publication of information about the quality and performance of children's healthcare services at national level, at the level of individual trusts, and of individual consultant units. (July 2001)	The Government agreed with this recommendation and said it would be considered as part of the National Service Framework.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**177**	There must be much greater integration of primary, community, acute and specialist healthcare for children. The National Service Framework should include strategic guidance to health authorities and trusts so that services in the future are better integrated and organised around the needs of children and their families. (July 2001)	The Government agreed with this recommendation. Integration was addressed in the National Service Framework for Children: Standard for Hospital Services, published in April 2003.	The Department of Health's Response to the BRI Inquiry, January 2002. National Service Framework for Children Standard for Hospital Services, April 2003.	

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Improving patient safety	**178**	Children's acute hospital services should ideally be located in a children's hospital, which should be physically as close as possible to an acute general hospital. This should be the preferred model for the future. (July 2001)	In its January 2002 response, the Department of Health said it would consider evidence on service configuration through development of the National Service Framework.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**179**	In the case of existing free-standing children's hospitals, particular attention must be given to ensuring that, through good management and organisation of care, children have access when needed to (a) facilities which may not routinely be found in a children's hospital and (b) specialists, the appointment of whom in a children's hospital could not be justified given the infrequent call on their services. (July 2001)	In its January 2002 response, the Department of Health said it would consider evidence on service configuration through development of the National Service Framework.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**180**	Consideration should be given to piloting the introduction of a system whereby children's hospitals take over the running of the children's acute and community services throughout a geographical area, building on the example of the Philadelphia Children's Hospital in the USA. (July 2001)	In its January 2002 response, the Department of Health said it would consider evidence on service configuration through development of the National Service Framework.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**181**	Specialist services for children should be organised so as to provide the best available staff and facilities, thus providing the best possible opportunity for good outcomes. Advice should be sought from experts on the appropriate number of patients to be treated to achieve good outcomes. In planning and organising specialist services, the	In its January 2002 response, the Department of Health said it would consider evidence on optimal workload in relation to outcomes in the Paediatric and Cardiac Congenital Services Review and the National Service Framework process.	The Department of Health's Response to the BRI Inquiry, January 2002.	

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		requirements of quality and safety should prevail over considerations of ease of access. (July 2001)			
	182	Where specialist services for children are concentrated in a small number of trusts spread throughout England, these trusts should establish Family Support Funds to help families to meet the costs arising from travelling and staying away from home. The Funds should be administered flexibly and should not be limited to those on income support or with low incomes. (July 2001)	The Government rejected this recommendation. In its January 2002 response, the Department of Health rejected any proposal to extend the hospital travel costs scheme, but said it would encourage trusts to use their discretionary powers to support families visiting relatives, including children.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving NHS culture and governance	**183**	After completion of a pilot exercise, all trusts which provide acute hospital services for children should be subject to a process of validation to ensure that they have appropriate child- and family-centred policies, staff, and facilities to provide a good standard of care for children. Trusts which are not so validated should not, save in emergencies, provide acute hospital services for children. (July 2001)	In its January 2002 response, the Department of Health rejected the concept of validation, but said it agreed in principle that arrangement for inspection and performance management would include children's services.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**184**	Children should always (save in exceptional circumstances, such as emergencies) be cared for in a paediatric environment, and always by healthcare professionals who hold a recognised qualification in caring for children. This is especially so in relation to paediatric intensive care. (July 2001)	The Government agreed with this recommendation. The National Service Framework for Children: Standard for Hospital Services, published in April 2003, contained the standard, "*Care will be provided in an appropriate location and in an environment that is safe and well-suited to the age and stage of development of the child or young*	The Department of Health's Response to the BRI Inquiry, January 2002. National Service Framework for Children Standard for Hospital	

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			person." The document went on to explain that this meant children should not be cared for on adult wards.	Services, April 2003.	
Improving patient safety	**185**	The 1991 standards for the numbers of paediatrically qualified nurses required at any given time should serve as the minimum standard and should apply where children are treated (save in emergencies). The standards should be reviewed as a matter of urgency to take account of changing patterns in the provision of acute healthcare services. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that the 1991 standards for the numbers of qualified paediatric nurses would be reviewed as part of the National Service Framework.	The Department of Health's Response to the BRI Inquiry, January 2002.	
Improving patient safety	**186**	All surgeons who operate on children, including those who also operate on adults, must undergo training in the care of children and obtain a recognised professional qualification in the care of children. As a matter of priority, the General Medical Council, the body responsible for the revalidation of doctors, should agree with the Royal College of Surgeons of England the appropriate number and range of procedures which surgeons who operate on children must undertake in order to retain their validation. This will have consequences for the way in which general surgery for children is organised.	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said it would work with the professional organisations to ensure all surgeons who operated on children were appropriately trained and undertook an appropriate number of procedures. Revalidation requirements for doctors were not introduced by the General Medical Council until December 2012.	The Department of Health's Response to the BRI Inquiry, January 2002. Revalidation - Current State of Play. Revalidation Process. | Patient	
Improving patient safety	**187**	Parents should ordinarily be recognised as experts in the care of their children, and when their children are in need of healthcare, parents should ordinarily be fully involved in that care. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said parents should normally be fully involved in the care of	The Department of Health's Response to the BRI Inquiry, January 2002.	

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			their children and that this would be reflected in the National Service Framework.		
Improving patient safety	**188**	Parents of very young children have particular knowledge of their child. This knowledge must be valued and taken into account in the process of caring for the child, unless there is good reason to do otherwise. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said parental knowledge of their children should be taken into account in caring for the child.	The Department of Health's Response to the BRI Inquiry, January 2002.	
	189	Children's questions about their care must be answered truthfully and clearly. (July 2001)	The Government agreed in principle with this recommendation. In its January 2002 response, the Department of Health said parents still needed to be involved in decisions about what individual children were told.	The Department of Health's Response to the BRI Inquiry, January 2002.	
	190	Healthcare professionals intending to care for children should be trained in the particular skills necessary to communicate with parents and with children. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that healthcare professionals would be trained in communication skills and this would be achieved through changes in basic training and continuing professional development.	The Department of Health's Response to the BRI Inquiry, January 2002.	
	191	Healthcare professionals should be honest and truthful with parents in discussing their child's condition, possible treatment and the possible outcome. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that its consent initiative would support healthcare staff, patients and their families in reaching decisions based on a full and honest appraisal of the information and facts	The Department of Health's Response to the BRI Inquiry, January 2002.	

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			available. The Department referred to its publication of a model consent policy and model consent forms in November 2001.	Report of the Paediatric & Congenital Cardiac Services Review Group, December 2003	
Improving patient safety	**192**	National standards should be developed, as a matter of priority, for all aspects of the care and treatment of children with congenital heart disease. The standards should address diagnosis, surgical and other treatments, and continuing care. They should include standards for primary and social care, as well as for hospital care. The standards should also address the needs of those with congenital heart disease who grow into adulthood. (July 2001)	The Government agreed with this recommendation. The Paediatric and Congenital Cardiac Services Review Group published its report in December 2003. The report contained a number of standards, addressing medical and surgical care, primary care, joined-up care and care for patients as they grew up.	The Department of Health's Response to the BRI Inquiry, January 2002. Report of the Paediatric & Congenital Cardiac Services Review Group, December 2003	
Improving patient safety	**193**	With regard to paediatric cardiac surgery, the standards should stipulate the minimum number of procedures which must be performed in a hospital over a given period of time in order to have the best opportunity of achieving good outcomes for children. Paediatric cardiac surgery must not be undertaken in hospitals which do not meet the minimum number of procedures. Considerations of ease of access to a hospital should not be taken into account in determining whether paediatric	The Paediatric and Congenital Cardiac Services Review Group published its report in December 2003. The report contained a number of standards. However, it rejected the need for the standards to stipulate the minimum number of procedures that should be performed by a centre over a given period of time, saying there was limited evidence to support such a standard or to help determine what the minimum level should be.	The Department of Health's Response to the BRI Inquiry, January 2002. Report of the Paediatric & Congenital Cardiac Services Review Group, December 2003	

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		cardiac surgery should be undertaken at that hospital. (July 2001)			
Improving patient safety	**194**	With regard to those surgeons who undertake paediatric cardiac surgery, although not stipulating the number of operating sessions sufficient to maintain competence, it may be that four sessions a week should be the minimum number required. Agreement on this should be reached as a matter of urgency after appropriate consultation. (July 2001)	The Paediatric and Congenital Cardiac Services Review Group published its report in December 2003. The report contained a number of standards and the Review Group endorsed the recommendation that surgeons should avoid occasional practice and devote a minimum of 4 operating sessions per week, on average, to the congenital service.	The Department of Health's Response to the BRI Inquiry, January 2002. Report of the Paediatric & Congenital Cardiac Services Review Group, December 2003	
Improving patient safety	**195**	With regard to the very particular circumstances of open-heart surgery on very young children (including neo-nates and infants), we stipulate that the following standard should apply unless, within six months of the publication of this Report, this standard is varied by the Department of Health having taken the advice of relevant experts: there must, in any unit providing open-heart surgery on very young children, be two surgeons trained in paediatric surgery who must each undertake between 40 and 50 open-heart operations a year. (July 2001)	The Paediatric and Congenital Cardiac Services Review Group published its report in December 2003. The report contained a number of standards and the Review Group endorsed the recommendation that it would be unsafe for any surgeon to be performing fewer than 40 open-heart procedures a year on neonates and infants.	The Department of Health's Response to the BRI Inquiry, January 2002. Report of the Paediatric & Congenital Cardiac Services Review Group, December 2003	
Improving patient safety	**196**	The national standards should stipulate that children with cardiac heart disease who undergo any form of interventional procedure must be cared	The Paediatric and Congenital Cardiac Services Review Group published its report in December 2003. The report contained a number of standards, including that "*children*	The Department of Health's Response	

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		for in a paediatric environment. This means that all healthcare professionals who care for these children must be trained and qualified in paediatric care. It also means that children must be cared for in a setting with facilities and equipment designed for children. There must also be access on the same site as where any surgery is performed to a paediatric intensive care unit, supported by trained intensivists.	*should be cared for in an environment that recognises their special needs"*.	to the BRI Inquiry, January 2002. Report of the Paediatric & Congenital Cardiac Services Review Group, December 2003	
Improving patient safety	**197**	Surgical services for children with very rare congenital heart conditions, such as Truncus Arteriosus, or involving procedures undertaken very rarely; should only be performed in a maximum of two units, validated as such on the advice of experts. Such arrangements should be subject to periodic review. (July 2001)	The Paediatric and Congenital Cardiac Services Review Group published its report in December 2003. In its report, the Review Group stated that this approach would be unduly restrictive.	The Department of Health's Response to the BRI Inquiry, January 2002. Report of the Paediatric & Congenital Cardiac Services Review Group, December 2003	
Improving patient safety	**198**	An investigation should be conducted as a matter of urgency to ensure that paediatric cardiac surgery is not currently being carried out where the low volume of patients or other factors make it unsafe to perform such surgery. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said a thorough review of services was underway.	The Department of Health's Response to the BRI Inquiry, January 2002.	

7 INDEPENDENT INVESTIGATION INTO HOW THE NHS HANDLED ALLEGATIONS ABOUT THE CONDUCT OF CLIFFORD AYLING

7.1 Introduction

A Committee of Inquiry commissioned by the Secretary of State for Health in July 2001 to investigate how the NHS handled allegations about the conduct of Clifford Ayling. The Inquiry was chaired by Dame Anna Pauffley. The report of the Inquiry was delivered on 15 July 2004. The report can be viewed online.

Clifford Ayling was a GP who was convicted in December 2000 on 12 counts of indecent assault, relating to 10 female patients. The Inquiry was tasked with:

- Documenting and establishing the concerns and complaints made about Clifford Ayling during the time he practised;
- Investigating the actions which were taken for the purpose of considering and acting upon the concerns and complaints which were raised;
- Investigating cultural or other organisational factors which impeded or prevented appropriate investigation and action; and
- To make recommendations as to improvements which should be made to the policies and procedures in place within the health service.

The Inquiry identified a number of missed opportunities between 1977 and 1998 when concerns and complaints about Clifford Ayling could have been acted on. Specific failures identified included a lack of support for patients who wished to make complaints; a defensive cultural response to complaints; and an absence of formal procedures to express concerns, with preference for informal systems which were ineffective.

The Inquiry made 18 recommendations. The Government responded to the report of the Inquiry, and the recommendations it made, in its February 2007 report titled '*Safeguarding Patients: The Government's response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries*'.

7.2 The Ayling Inquiry: Table of Recommendations

The Ayling Inquiry					
Type of Recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
Improving patient safety	**1**	The Department of Health should convene an expert group under the auspices of the Chief Medical Officer to develop guidance and best practice for the NHS on the subject of "sexualised behaviour" amongst health professionals. The group should include the NHS Confederation, the Royal College of Obstetricians and Gynaecologists, the Royal College of GPs (and other Colleges as appropriate, such as the Royal College of Psychiatrists), the National Clinical Assessment Authority, the Council for the Regulation of Healthcare Professionals, the General, Medical Council and representatives of undergraduate and postgraduate medical education. The group should take advice from experience of dealing with "sexualised behaviour" elsewhere in the public sector such as educational services and from health care systems in other countries such as Canada. (July 2004)	In the February 2007 Safeguarding Patients report, the Government said it had invited the Council for Healthcare Regulatory Excellence to lead a project involving relevant stakeholders to develop a comprehensive suite of guidance in this area. Guidance was published by the Council for Healthcare Regulatory Excellence in January 2008.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals, Council for Healthcare Regulatory	

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				Excellence, January 2008.	
Improving the ability to raise complaints and concerns	**2**	Local policies within all NHS Trusts for reporting staff concerns (whistleblowing) should specifically identify sexualised behaviour as appropriate for reporting within the confidence of this procedure. (July 2004)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government proposed that all organisations providing services to the NHS should have a written policy setting out the procedure to be followed by staff wishing to raise concerns, and that it would discuss with stakeholders how this might best be achieved.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**3**	Accredited training should be provided for all Patient Advice and Liaison Service officer in this potential aspect of their work, and strategic health authorities should require confirmation from each NHS Trust in their area of the completion of such training within the next 12 months. (July 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said the Department of Health had developed a training programme for the Patient Advice and Liaison Service and the Independent Complaints Advocacy Service, which had been rolled out nationally.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving the ability to raise complaints and concerns	**4**	The Modernisation Agency should develop a model of best practice for access to Patient Advice and Liaison Service and, if appropriate for them so to do, the patients' forums could monitor the effectiveness of service provision against this model. The implementation of this model and associated performance measures should be a formal component of the Commission for Healthcare Audit and Inspection's reviews of primary care trusts. (July 2004)	In the February 2007 Safeguarding Patients report, the Government said that the Department of Health had drawn up national standards for the work of the Patient Advice and Liaison Service and special health authorities were to be responsible for monitoring the quality of the services offered against these standards. The Department of Health said it had also commissioned an independent evaluation of the impact of the Patient Advice and Liaison Service. The role of the Patient Advice and Liaison Service would be considered in a further consultation.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**5**	The same training for the Independent Complaints Advocacy Service staff in handling concerns and complaints of an intimate and sensitive nature as that recommended for Patient Advice and Liaison Service staff should be provided, and this should form part of the service specification for the Independent Complaints Advocacy Service. Satisfaction surveys should be built into the work of the Independent Complaints Advocacy Service on completion of their work with each complaint so that their performance can be routinely monitored and a cycle of continuous improvement can be established. (July 2004)	In the February 2007 Safeguarding Patients report, the Government said the Department of Health had developed a training programme for the Patient Advice and Liaison Service and the Independent Complaints Advocacy Service, which had been rolled out nationally. The Government also referred to the Department of Health routinely working with all Independent Complaints Advocacy Service providers to increase the amount of feedback from clients and reviewing the way this information is used to develop the service.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**6**	All NHS Trusts and health care organisations such as deputising services directly employing staff should require them (and particularly part-time staff)	The Government's response was silent on whether there would be a requirement for a formal declaration. Instead, the Government said it was considering ways of underlining	Safeguarding Patients: The Government's	

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		to make a formal declaration of any other concurrent employment, not only for obvious health and safety reasons but also to ensure a record is kept of other organisations with an interest in the individual's performance. Failure to make such a declaration should be a disciplinary matter. This requirement should be appropriately adapted for primary care trusts to be kept informed of other professional employment undertaken by GPs. (July 2004)	the importance of ensuring awareness of concurrent employment, for instance by imposing a statutory duty on health organisations to share information about health professionals where needed to safeguard patients.	Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**7**	Copies of any written records regarding complaints and concerns and the outcome of these which name an individual practitioner should be placed on that practitioner's personnel file, to be kept for the length of their contract with that organisation. This should be made known to the practitioner concerned. (July 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said that the Department of Health, or another central organisation such as NHS Employers, would issue guidance on the content of files to be kept by primary care trusts and employers, and also on the principle for creating and giving access to records.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**8**	The regular reports on patient complaints and concerns made to NHS Trust Boards and other corporate governance bodies should be structured to provide an analysis not only of trends in subject matter and clinical area but also to indicate whether	In the February 2007 Safeguarding Patients report, the Government said it agreed that clinical governance staff in healthcare organisations should analyse data on complaints and concerns in order to identify any clusters relating to individual health professionals. However, it would not necessarily expect the individuals to be named in	Safeguarding Patients: The Government's Response to the recommendations of the Shipman	

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		a named practitioner has been the subject of previous complaints. (July 2004)	reports to the Trust Board unless further investigation confirmed there was significant cause for concern.	Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	9	Primary care trusts should develop specific support programmes for single-handed practitioners, to be agreed with the practitioner concerned and the primary care trust's strategic health authority. Such programmes should pay critical attention to managing the risks of clinical and professional isolation associated with single-handed practice. Implementation should be monitored by the strategic health authority and form part of the regular Commission for Healthcare Audit and Inspection. (July 2004)	The Government agreed with this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said the Department of Health would discuss further with the NHS and professional organisations what support would be appropriate.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	10	Additionally, primary care trusts should pay particular attention to developing and supporting the independence of practice managers in single-handed practices, including the acknowledgement and resolution of potential conflicts of interest which may arise where the manager is the spouse or a close relative of the practitioners. This should be the subject of monitoring and review by strategic health	The Government agreed with this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said the Department of Health would discuss further with the NHS and professional organisations what support would be appropriate.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations	

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		authorities and the Commission for Healthcare Audit and Inspection. (July 2004)		of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**11**	No family member or friend of a patient should be expected to undertake any formal chaperoning role. The presence of a chaperone during a clinical examination and treatment must be the clearly expressed choice of a patient. Chaperoning should not be undertaken by other than trained staff: the use of untrained administrative staff as chaperones in a GP surgery is not acceptable. However, the patient must have the right to decline any chaperone offered if they so wish. (July 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said guidance on chaperoning policies for primary care organisations was issued in June 2005. The Government said it would discuss with NHS Employers whether specific guidance for secondary care providers was needed.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**12**	There is a need for each NHS Trust to determine its chaperoning policy, make this explicit to patients and resource it accordingly. This must include accredited training for the role and an identified managerial lead with responsibility for the implementation of the policy. For primary care, developing and resourcing a chaperoning policy would have to take into account issues such as one-to-one consultations in the patient's home and the capacity of individual practices to meet the requirements of the agreed policy. (July 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said guidance on chaperoning policies for primary care organisations was issued in June 2005. The Government said it would discuss with NHS Employers whether specific guidance for secondary care providers was needed.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

The Ayling Inquiry					
				Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**13**	Reported breaches of the chaperoning policy should be formally investigated through each Trust's risk management and clinical governance arrangements and treated, if determined as deliberate, as a disciplinary matter. (July 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said it would ask the Council for Healthcare Regulatory Excellence to draw this recommendation to the attention of all healthcare organisations as part of the suite of guidance to be developed by the project to be led by the Council for Healthcare Regulatory Excellence.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**14**	Local medical committees should clarify their role in relation to supporting GPs to make it explicit that acting on the receipt of information about a GP which indicates patient safety is being compromised is not part of their role, and ensure that this is embedded in professional guidance from the General Medical Council and medical defence organisations. (July 2004)	In the February 2007 Safeguarding Patients report, the Government said it agreed that primary care trusts should have an overview of all concerns raised about the conduct of performance of health professionals working under contract for them and should take the final decision on whether any further action is needed. The Government said it would consult further with stakeholders and issue further guidance or amend the regulations as needed.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

The Ayling Inquiry					
Improving the ability to raise complaints and concerns	**15**	If local medical committees are the recipient of concerns about a practitioner's clinical conduct or performance, this information should be immediately passed on to the relevant primary care trust or professional regulatory body for appropriate investigation. This should be made known to their constituents. (July 2004)	In the February 2007 Safeguarding Patients report, the Government said it agreed that primary care trusts should have an overview of all concerns raised about the conduct of performance of health professionals working under contract for them and should take the final decision on whether any further action is needed. The Government said it would consult further with stakeholders and issue further guidance or amend the regulations as needed.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**16**	There should be set out in a Memorandum of Understanding (such as exists between the General Medical Council and the National Clinical Assessment Authority) between the NHS, professional regulatory bodies as the General Medical Council and the Crown Prosecution Service a clear agreement as to the responsibilities of each organisation in the investigation of potential criminal activity by healthcare professionals. This should then be promulgated to the NHS and built into guidance. (July 2004)	The Association of Police Officers, the NHS and the Health and Safety Executive published in February 2006 a Memorandum of Understanding, setting out the responsibilities and roles of each party, procedure for liaison, clarity over responsibility for initial investigation, sharing information and supporting those harmed, other patients, relatives and NHS staff. An information sharing protocol was signed by the Association of Police Officers, the Crown Prosecution Service, the Nursing and Midwifery Council and the General Medical Council in July 2006. This was subsequently followed by a Memorandum of Understanding between those organisations. In the February 2007 Safeguarding Patients report, the Government said that guidance on the thresholds at which issues of professional competence should be referred to	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Memorandum of Understanding: Investigating patient safety	

The Ayling Inquiry					
			the professional regulators would be developed by the Council for Healthcare Regulatory Excellence.	incidents involving unexpected death or serious untoward harm, Department of Health, ACPO, HSE, February 2006. Memorandum of Understanding, ACPO, CPS, NMC and GMC, undated.	
Improving patient safety	**17**	Strategic health authorities should work together with the Department of Health to produce guidance for primary care trusts and other NHS Trusts in handling incidents involving potentially criminal activity. (July 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said it would issue guidance covering all aspects of investigation by healthcare organisations after consultation with stakeholders.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	18	Part of the guidance should specifically address a patient communications strategy and the involvement of victim support services. (July 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said it would ensure that the this was covered	Safeguarding Patients: The Government's Response to the	

The Ayling Inquiry					
			in the guidance referred to in relation to the previous recommendation.	recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

8 COMMITTEE OF INQUIRY TO INVESTIGATE HOW THE NHS HANDLED ALLEGATIONS ABOUT THE PERFORMANCE AND CONDUCT OF RICHARD NEALE

8.1 Introduction

A Committee of Inquiry commissioned by the Secretary of State for Health in July 2001 to investigate how the NHS handled investigations about the performance and conduct of Richard Neale. The Inquiry was chaired by Her Honour Judge Suzan Matthews QC. The report of the Inquiry was delivered on 19 August 2004.

Richard Neale was a Consultant Gynaecologist who was struck off from the General Medical Register in July 2000 after being found to have failed to provide appropriate care to patients and lied about his qualifications. The Inquiry was tasked with:

- Identifying the procedures in place from 1985 to 1995 to enable members of the public to raise concerns or complaints;
- Documenting and establishing the concerns or complains raised concerning the practice and conduct of Richard Neale;
- Investigating the actions which were taken for the purpose of considering and acting upon the concerns and complaints raised;
- Investigating cultural or other organisational factors which impeded or prevented appropriate investigation and action; and
- Making recommendations as to improvements which should be made to the policies and procedures in place within the health service.

The Inquiry found that the climate in which Richard Neale operated did not permit full and objective examination of his performance. Specific failures identified included an inadequacy of checks on his clinical ability by his peers; failure by the General Medical Council to take fitness to practise action; inadequacy of response by the regional health authority; and culture and procedures which dissuaded complaints and failed to take them seriously.

The Inquiry made 27 recommendations. The Government responded to the report of the Inquiry, and the recommendations it made, in its February 2007 report titled '*Safeguarding Patients: The Government's response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries*'.

8.2 The Richard Neale Inquiry: Table of Recommendations

The Richard Neale Inquiry					
Type of Recommendation	No.	Details of Recommendation	Implementation	Source	Extent of Implementation
Improving NHS culture and governance	**1**	The Secretary of State for Health should consider setting up a new body, or expanding the power of an existing body such as the Council for Regulation of Healthcare Professionals to take an overarching view of all aspects of the rules governing the appointment and employment of doctors. This body should have necessary powers of investigation in the wider interests of patient safety, ensuring a robust and consistent approach to individual concerns that may arise in the future. (August 2004)	In the February 2007 Safeguarding Patients report, the Government said that guidance to the NHS on good employment practice fell within the remit of NHS Employers, a part of the NHS Confederation. The Government considered it would confuse NHS organisations to set up a further body for this purpose. It is unclear what powers of investigation NHS Employers had or was given.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**2**	Security of tenure for NHS Consultants with a protective appeal procedure to the Secretary of State should be abolished. (August 2004)	In the February 2007 Safeguarding Patients report, the Government said that the 'para 190' right of appeal to the Secretary of State was abolished in 2005, with consultants being under the same disciplinary arrangements for misconduct as other members of staff.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

The Richard Neale Inquiry					
				Inquiries, February 2007.	
Improving patient safety	**3**	The contents of the model declaration forms referred to in HSC2002/08 should be made mandatory in the NHS. (August 2004)	In the February 2007 Safeguarding Patients report, the Government said that HSC2002/08 had since been superseded by more recent guidance updated in January 2007. The Government stated it would consider how the new regulatory framework could be best be used to promote adoption of best practice in relation to model declaration forms. It does not appear that model declaration forms are currently mandatory.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Seeking a self-declaration from applicants | NHS Employers	
Improving patient safety	**4**	For all doctor appointments made directly from overseas, regardless of where they qualified, employing authorities should check with the issuing body the recommended applicant's primary and postgraduate qualifications and confirm fitness to practise. (August 2004)	In the February 2007 Safeguarding Patients report, the Government said it considered it was for professional regulators to check the primary qualification for healthcare professionals appointed from overseas. The Government agreed that NHS organisations should check other postgraduate qualifications and said it would ask NHS Employers to reflect this in guidance.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations	

The Richard Neale Inquiry					
			Current NHS Employers Guidance requires employers to request and check original documentation for qualifications from applicants. However, it merely advises that employers may contact awarding bodies directly where there is a discrepancy or concern about the authenticity of documentation provided by an individual, with the consent of the applicant.	of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**5a**	All references by employing authorities should specify the areas they require to be addressed by the referee. (August 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said this was already good practice, but the Department of Health would ask NHS Employers to ensure it was explicitly reflected in guidance. Current NHS Employers Guidance recommends use of a standardised reference request template to help referees identify what information they need to provide more easily, as well as advising on what details references should aim to provide.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Employment history and reference checks standard | NHS Employers	
Improving patient safety	**5b**	No agreement should ever be entered into to provide a reference, which in anyway negates the	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said it had asked the Council on Healthcare	Safeguarding Patients: The Government's	

The Richard Neale Inquiry					
		view that the interests and safety of the patient are paramount. (August 2004)	Regulatory Excellence to ensure that all professional regulators gave guidance on the ethical responsibilities of referees. The Government also stated that the General Medical Council's guidance 'Good Medical Practice' already included provision to this effect.	Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**6**	Only a fully completed standard application form with room for additional information should be acceptable. Amended, substituted or adapted forms should not be used for any reason. (August 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said this was already good practice, but the Department of Health would ask NHS Employers to ensure it was explicitly reflected in guidance.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**7**	Clear roles should be established for all those on an interview panel and full note of proceedings should be taken and retained. (August 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said this was already good practice, but the	Safeguarding Patients: The Government's Response to the recommendations of the Shipman	

The Richard Neale Inquiry					
			Department of Health would ask NHS Employers to ensure it was explicitly reflected in guidance.	Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**8**	All previous contacts between applicant and interviewers should be disclosed and recorded. (August 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said this was already good practice, but the Department of Health would ask NHS Employers to ensure it was explicitly reflected in guidance.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**9**	Any undisclosed championing of applicants should be disclosed and recorded. (August 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said this was already good practice, but the Department of Health would ask NHS Employers to ensure it was explicitly reflected in guidance.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations	

The Richard Neale Inquiry					
				of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**10**	The application form should contain a declaration that all information is correct to the best of the applicant's knowledge and belief and any matter, professional or personal unresolved or pending that might undermine the applicant's standing, or cause embarrassment to the NHS, should be declared by a confidential side letter to the chairman. The penalty for failure to disclose such information should be summary dismissal. (August 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said this was already good practice, but the Department of Health would ask NHS Employers to ensure it was explicitly reflected in guidance.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**11**	The NHS should give consideration to instruct employers to include a condition that clinical employees must declare any police cautions or convictions to the employer as they arise after the commencement of their employment. (August 2004)	In the February 2007 Safeguarding Patients report, the Government said that guidance from NHS Employers already advised inclusion of such a condition in contracts of employment. The Government also stated that all health professionals were under an ethical obligation to report cautions and convictions to their professional regulator.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

The Richard Neale Inquiry					
				Inquiries, February 2007.	
Improving patient safety	**12**	The Panel Chairman should be responsible for ensuring that referees are contacted by telephone and content of the references should be confirmed at or around the time of appointment. (August 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said this was already good practice, but the Department of Health would ask NHS Employers to ensure it was explicitly reflected in guidance.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	13	The police check should include convictions, cautions and entries on the sex offenders Register. (August 2004)	In the February 2007 Safeguarding Patients report, the Government said that since February 2005 it had been mandatory for all NHS employers to arrange for checks at the Criminal Records Bureau for all relevant NHS staff. This would show current and spent convictions, cautions, reprimands and warnings held on the Police National Computer.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

The Richard Neale Inquiry					
Improving patient safety	**14**	Employing authorities/medical colleagues should not give a reference which is capable of being misleading by omission. (August 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said this was already good practice, but the Department of Health would ask NHS Employers to ensure it was explicitly reflected in guidance. The Government also said it had asked the Council on Healthcare Regulatory Excellence to ensure that all professional regulators gave guidance on the ethical responsibilities of referees.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	15	Patients should receive copies of letters sent to and from their general practitioners and in the template of the letter sent to all patients, the doctor should confirm, "I have discussed the condition and treatment with the patient." (August 2004)	In the February 2007 Safeguarding Patients report, the Government said it agreed that patients should have the opportunity to receive copies of letters between their GPs and specialist clinicians, with written information reinforcing the information they have already been given in consultation. The Department of Health announced a 'Copying letters to patients' initiative in 2000 and issued further guidance on its implementation in 2003. The Government said the guidance included suggested templates and made clear that patients should be asked whether they wished to receive copies of letters.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	16	In the patient's copy of the discharge letter the doctor should complete as appropriate, that, "the procedure went to plan/had the following	In the February 2007 Safeguarding Patients report, the Government repeated its response to Recommendation 15 but stated that it would be poor practice to give patients	Safeguarding Patients: The Government's	

The Richard Neale Inquiry					
		complications… This has/has not been discussed with the patient". (August 2004)	information in writing which had not previously been discussed face to face. The Government said it did not want to be prescriptive about the level of detail of information disclosed by clinicians to patients.	Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	17	If a consultant has not performed a procedure or part of a procedure himself he should legibly identify who did and whether it was under supervision. Patients should know who operated on them. (August 2004)	In the February 2007 Safeguarding Patients report, the Government said it did not want to be prescriptive about the level of detail of information disclosed by clinicians to patients.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**18**	Clear procedures should be set up so that the patient may give consent for a nominated third party to act as their advocate in raising concerns if they are unable to do so. (August 2004)	The Government agreed with this recommendation. The February 2007 Safeguarding Patients report, the Government said that this power already existed in the complaints regulations and, as part of the review of the	Safeguarding Patients: The Government's Response to the recommendations of the Shipman	

The Richard Neale Inquiry					
			complaints procedures, it would ensure that patients and carers were made aware of the position.	Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**20**	Doctors should spend time observing the Patient Advocacy and Liaison Service process and be familiar with the process. (August 2004)	In the February 2007 Safeguarding Patients report, the Government said that this was already common practice and that many Patient Advocacy and Liaison Service staff already provided input to induction and other training programmes for clinical staff.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**21**	Unified and centralised training should be provided for all Patient Advocacy and Liaison Service officers. (August 2004)	In the February 2007 Safeguarding Patients report, the Government said that the Department of Health set national standards for Patient Advocacy and Liaison Service training, but strategic health authorities had an important role in ensuring that local health communities carried out an appropriate analysis of specific training needs and provided the training required. Centralised training was not the norm.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations	

The Richard Neale Inquiry					
				of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**22**	Complaints handling should be aligned to quality management and patient services rather than claims management. (August 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said that complaints handling should be regarded as an integral part of clinical governance and complaints seen as a vital source of information. The Government stated it would consider with stakeholders how existing statutory responsibility could be strengthened. The Government subsequently enacted the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009	
Improving the ability to raise complaints and concerns	**23**	The head of the unit dealing with complaints should be an appropriately trained manager. (August 2004)	In the February 2007 Safeguarding Patients report, the Government said it agreed that complaints handlers in primary care trusts or hospital trusts should be appointed at a sufficiently senior level and with appropriate training, and that they should have direct access to the member of the	Safeguarding Patients: The Government's Response to the recommendations	

The Richard Neale Inquiry					
			executive board with overall responsibility with clinical governance issues.	of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**24**	Complaints handling training should be mandatory for all levels of clinical, nursing and administrative staff. (August 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said that it would address the implications for training and induction processes in a wider review of the complaints handling system.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**25**	The National Patient Safety Agency should take the lead in developing adverse event reporting systems. Data taken from complaints should be integrated with and/or read alongside other data from such sources as confidential reports on near misses, patient satisfaction surveys and clinical and medical audit. (August 2004)	In the February 2007 Safeguarding Patients report, the Government said that the core role of the National Patient Safety Agency was to collect patient safety incident data from local reporting systems and other sources through the National Reporting and Learning System and the Patient Safety Observatory. The Government said that the National Patient Safety Agency and the Department of Health were	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the	

The Richard Neale Inquiry					
			reviewing the future role of the National Patient Safety Agency.	recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**26**	Complaints statistics should be included in the Profiles of Trusts and used by the Commission for Healthcare Audit and Inspection (now referred to as the Healthcare Commission) in routine audit procedures. (August 2004)	In the February 2007 Safeguarding Patients report, the Government said that this was already the case.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**27**	Statutory provision should be made to encourage the reporting of adverse events. (August 2004)	In the February 2007 Safeguarding Patients report, the Government said it agreed with the importance of encouraging health professionals to report concerns about the safety of services but considered this was better promoted by professional ethical guidance rather than through statutory provision. The Government referred to a proposed 'duty of candour' being rejected by Parliament during debate on the 2006 NHS Redress Act.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

The Richard Neale Inquiry					
			A duty of candour was subsequently implemented via Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.	Inquiries, February 2007. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	

9 THE SHIPMAN INQUIRY

9.1 Introduction

A public inquiry set up to investigate the activities of general practitioner and serial killer Harold Shipman. The Inquiry was chaired by Dame Janet Smith DBE. The first report of the Inquiry was published on 19 July 2002 and its final report on 27 January 2005.

The reports can be viewed online.

The Inquiry was tasked with:

- Considering the extent of Harold Shipman's unlawful activities;
- Enquiring into the actions of the statutory bodies, authorities, other organisations and responsible individuals concerned in the procedures and investigations which followed the deaths of those of Harold Shipman's patients who died in unlawful or suspicious circumstances.
- Enquiring into the performance of the functions of those statutory bodies, authorities, other organisations and individuals with responsibility for monitoring primary care provision and the use of controlled drugs; and
- Recommending what steps, if any, should be taken to protect patients in the future.

The Inquiry published six reports. The first and sixth reports detailed the extent of Harold Shipman's unlawful activities. The second report examined the conduct of the police investigation into Harold Shipman which took place in March 1998 and failed to uncover his crimes. The third report considered the system for death and cremation certification and for the investigation of deaths by coroners. The fourth report considered the systems for the management and regulation of controlled drugs. The fifth report considered the handling of complaints against general practitioners, the raising of concerns and the General Medical Council's procedures.

The Inquiry made recommendations in the second to fifth reports.

9.2 The Shipman Inquiry: Table of Recommendations

(a) The Second Report of the Shipman Inquiry (14 July 2003)

The Shipman Inquiry: Second Report					
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
	1	Some guidance should be issued to detective officers who have to undertake investigations into allegations of wrongdoing by health professionals. Police need an established route by which to seek appropriately qualified and independent expert advice to assess the evidence gathered and to advise on the issues of culpability. If and when the medical coroner service comes into being, it would be appropriate for a medical coroner or a regional medical coroner to maintain a register of suitable experts and to provide confidential advice to the police. (July 2003)	The 2006 edition of the *Murder Investigation Manual* contained an entry on carrying out investigations of unexpected deaths, or other incidents leading to serious harm of patients, following treatment by health professionals. The Association of Police Officers, the NHS and the Health and Safety Executive published in February 2006 a Memorandum of Understanding, setting out the responsibilities and roles of each party, procedure for liaison, clarity over responsibility for initial investigation, sharing information and supporting those harmed, other patients, relatives and NHS staff.	Learning from tragedy, keeping patients safe - Overview of the Government's action programme in response to the recommendations of the Shipman Inquiry CM 7014 Murder Investigation Manual, National Centre for Policing Excellence, 2006. Memorandum of Understanding: Investigating patient safety incidents involving unexpected death or serious untoward	

The Shipman Inquiry: Second Report					
				harm, Department of Health, ACPO, HSE, February 2006.	
	2	If and when the medical coroner service comes into being, it would be appropriate for a medical coroner or a regional medical coroner to maintain a register of suitable experts and to provide confidential advice to the police. (July 2003)	In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024.	Ministerial Statement of the Parliamentary Under Secretary of State for the Minister for Women and the Minister for Mental Health and Women's Health Strategy, 27 April 2023.	
	3	The police should invite the Crown Prosecution Service to provide access to an in-house solicitor with medico-legal experience. Such a solicitor should have available lists of suitable experts and of counsel with specialist medico-legal knowledge. (July 2003)	Implementation status unknown.		

(b) The Third Report of the Shipman Inquiry (14 July 2003)

The Shipman Inquiry: Third Report					
Type of Recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
	1	The coronial system should be retained, but in a form entirely different from at present. There must be radical reform and a complete break with the past, as to organisation. (July 2003)	The Government enacted the Coroners and Justice Act 2009. The Coroners and Justice Act 2009: • Created the office of Chief Coroner, to act as the national head of the coroner system and provide judicial oversight of the coroner system. • Required all newly-appointed coroners to be legally qualified. • Maintained local authority responsibility for funding local coroner services. • Permitted coroners to delegate administrative functions to their officers and other support staff. • Introduced the concept of the coroner's investigation into a death, of which the inquest only forms a part, recognising time spent by coroners to consider whether the duty to hold an inquest applied and permitting coroners to make preliminary inquiries. • Removed the duty to investigate a death where it is sudden. • Elevated prevention of future death reports to primary legislation. The Coroners and Justice Act 2009 made provision for medical examiners to have a role in death certification.	Coroners and Justice Act 2009. The Chief Coroner's Guide to the Coroners and Justice Act 2009 Notification of Deaths Regulations 2019.	

The Shipman Inquiry: Third Report					
			However, these provisions were not initially brought into force. From 1 April 2019, there was roll-out of a non-statutory system of medical examiners, whereby NHS trusts were encouraged to set up new medical examiner services to replace existing death certification processes. The Notification of Deaths Regulations 2019 came into force, providing statutory categorisation of the circumstances in which a medical practitioner was required to report a death to the coroner. In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023.		
	2	The aim of the new Coroner Service should be to provide an independent, cohesive system of death investigation and certification, readily accessible to and understood by the public. It should seek to establish the cause of every death and to record the formal details accurately, for the purposes of registration and the collection of mortality statistics. It should seek to meet the needs and expectations of the bereaved. Its procedures should be designed to detect cases of homicide, medical error and neglect. It should provide a thorough and open investigation of all deaths giving rise to public	The Government enacted the Coroners and Justice Act 2009. The Coroners and Justice Act 2009: • Created the office of Chief Coroner, to act as the national head of the coroner system and provide judicial oversight of the coroner system. • Required all newly-appointed coroners to be legally qualified. • Maintained local authority responsibility for funding local coroner services.	Coroners and Justice Act 2009. The Chief Coroner's Guide to the Coroners and Justice Act 2009 The (Coroners) Investigations) Regulations 2013.	

The Shipman Inquiry: Third Report					
		concern. It should ensure that the knowledge gained from death investigation is applied for the prevention of avoidable death and injury in the future. (July 2003)	• Permitted coroners to delegate administrative functions to their officers and other support staff. • Introduced the concept of the coroner's investigation into a death, of which the inquest only forms a part, recognising time spent by coroners to consider whether the duty to hold an inquest applied and permitting coroners to make preliminary inquiries. • Removed the duty to investigate a death where it is sudden. • Elevated prevention of future death reports to primary legislation. The Coroners and Justice Act 2009 made provision for medical examiners to have a role in death certification. However, these provisions were not initially brought into force. From 1 April 2019, there was roll-out of a non-statutory system of medical examiners, whereby NHS trusts were encouraged to set up new medical examiner services to replace existing death certification processes. The Notification of Deaths Regulations 2019 came into force, providing statutory categorisation of the circumstances in which a medical practitioner was required to report a death to the coroner. In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the	Notification of Deaths Regulations 2019.	

The Shipman Inquiry: Third Report					
			Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023.		
	3	The Coroner Service should provide leadership, training and guidance for coroners, with the aim of achieving consistency of practice and a high quality of service throughout the country. (July 2003)	Implementation unknown.		
	4	The Coroner Service requires medical, legal and investigative expertise. (July 2003)	Implementation unknown.		
	5	Many of the functions currently carried out by coroners (who, in the main, have a legal qualification only) require the exercise of medical judgement. Some of those functions (and others which I am recommending) require legal expertise. In the future, those functions should be carried out respectively by a medical coroner and a judicial coroner. Both the medical and judicial coroners should be independent office-holders under the Crown. (July 2003)	This recommendation was not implemented by the Government. The Coroners and Justice Act 2009 did not create roles of medical coroners and judicial coroners. Conversely, newly-appointed coroners were required to be legally qualified.	Coroners and Justice Act 2009	
	6	The Coroner Service should have a corps of trained investigators, who would be the mainstays of the new system. The coroner's investigator would replace the coroner's officer but have a greatly enhanced role. More routine functions, at present performed by coroner's officers, would be	The Coroners and Justice Act 2009 permitted coroners to delegate administrative functions to their officers and other support staff. It also introduced the concept of the coroner's investigation into a death, of which the inquest only forms a part, recognising time spent by coroners to consider whether the duty to hold an inquest applied and permitting coroners to make preliminary inquiries.	Coroners and Justice Act 2009.	

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		performed instead by administrative staff. (July 2003)	However, no trained corps of trained investigators was created. The role of coroner's officer was maintained.		
	7	The Coroner Service must be, and must be seen to be, independent of Government and of all other sectional interests. It should not be administered, therefore, from within a Government Department. Instead, it should be a body at 'arm's length' from Government, that is an Executive Non-Departmental Public Body. Such bodies are formed in association with, but are independent of, the Government Department through which they are answerable to Parliament. Ideally, the Coroner Service, should be associated with both the Department for Constitutional Affairs and the Department of Health (in Wales, the National Health Service Wales Department of the National Assembly for Wales). (July 2003)	No Coroner Service as an Executive Non-Departmental Public Body was created. Coroners remained independent judicial office-holders, appointed by local authorities.	Coroners and Justice Act 2009.	
	8	The Coroner Service should be governed by a Board. Among the Board's responsibility would be the formulation of police, the strategic direction of the Service and the promotion of public education about such matters as the work of the Coroner Service and bereavement services. Three of the members of the Board would be the Chief Judicial Coroner, the Chief Medical Corner and the Chief Coroner's Investigator, each of whom be	No Coroner Service as an Executive Non-Departmental Public Body was created. Coroners remained independent judicial office-holders, appointed by local authorities. There is no Board which governs a national Coroner Service.	Coroners and Justice Act 2009.	

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		responsible for leading his/her respective branch of the service. (July 2003)			
	9	The Service should also have an Advisory Council, the function of which would be to provide policy advice on all issues. (July 2003)	No Coroner Service as an Executive Non-Departmental Public Body was created. Coroners remained independent judicial office-holders, appointed by local authorities. There is no Advisory Council which provides policy advice relating to the coroner service. Section 38 of the Coroners and Justice Act 2009, which makes provision for the appointment of medical advisers to the Chief Coroner, is yet to come into force.	Coroners and Justice Act 2009	
	10	The Coroner Service should be administered through a regional and district structure, which a regional medical coroner and at least one judicial coroner assigned to each region. There might also be a regional investigator. There would be ten regions in England and Wales, coinciding with the ten administrative regions. (July 2003)	As of October 2023, there were 83 coroner areas in England and Wales, with a long-term plan to reduce it to 75. Each jurisdiction is locally funded. Each area is led by a senior coroner. Some local authorities appoint one or more area coroners to support the senior coroner, in addition to the appointment of a number of assistant coroners.	Schedule 2 of the Coroners and Justice Act 2009 Coroners - Courts and Tribunals Judiciary	
	11	Each region should be divided into three to seven districts, each with a population of about a million. Each district office would have a medical coroner, one (possibly more than one) deputy medical coroner (who might work part-time), a team of coroner's investigators and a small administrative staff. The staff would operate a service outside the usual office hours. (July 2003)	As of October 2023, there were 83 coroner areas in England and Wales, with a long-term plan to reduce it to 75. Each jurisdiction is locally funded. Each area is led by a senior coroner. Some local authorities appoint one or more area coroners to support the senior coroner, in addition to the appointment of a number of assistant coroners.	Schedule 2 of the Coroners and Justice Act 2009 Coroners - Courts and Tribunals Judiciary	

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	12	The Coroner Service should have jurisdiction over every death that occurs in England and Wales and over every dead body brought within the boundaries. Jurisdiction should not depend upon a report being made or upon the need for an inquest. A death should be investigated in the district office most convenient in all the circumstances. (July 2003)	Under the Coroners and Justice Act 2009, senior coroners are under a duty to investigate deaths where they are made aware that a body of a deceased person is within that coroner's area and there is reason to suspect certain criteria apply. There is no need for a report to be made or for an inquest to be indicated.	Coroners and Justice Act 2009.	
	13	There should be one system of death certification applicable to all deaths, whether the death is to be followed by burial or cremation. (July 2003)	The Coroners and Justice Act 2009 made provision for medical examiners to have a role in death certification. However, these provisions were not initially brought into force. From 1 April 2019, there was roll-out of a non-statutory system of medical examiners, whereby NHS trusts were encouraged to set up new medical examiner services to replace existing death certification processes. The Notification of Deaths Regulations 2019 came into force, providing statutory categorisation of the circumstances in which a medical practitioner was required to report a death to the coroner. In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023. Regulations for the new death certification scheme are yet to be published.	Coroners and Justice Act 2009. Notification of Deaths Regulations 2019.	

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	14	There should be a requirement that the fact that a death has occurred should be confirmed and certified. (July 2003)	The Coroners and Justice Act 2009 made provision for medical examiners to have a role in death certification. However, these provisions were not initially brought into force. From 1 April 2019, there was roll-out of a non-statutory system of medical examiners, whereby NHS trusts were encouraged to set up new medical examiner services to replace existing death certification processes. The Notification of Deaths Regulations 2019 came into force, providing statutory categorisation of the circumstances in which a medical practitioner was required to report a death to the coroner. In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023. Regulations for the new death certification scheme are yet to be published.	Coroners and Justice Act 2009. Notification of Deaths Regulations 2019.	
Improving patient safety	**15**	The basis for the certification system would be the completion of two forms. The first (Form 1) would provide an official record of the fact and circumstances of the death. It would be completed by the person (a doctor, an accredited nurse or paramedic or a trained and accredited coroner's investigator) who had confirmed the fact that death had occurred. The second form (Form 2) would be completed by the doctor who had treated the	The Coroners and Justice Act 2009 made provision for medical examiners to have a role in death certification. However, these provisions were not initially brought into force. From 1 April 2019, there was roll-out of a non-statutory system of medical examiners, whereby NHS trusts were	Coroners and Justice Act 2009. Notification of Deaths Regulations 2019.	

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		deceased person during the last illness or, if no doctor had treated the deceased in the recent past, by the deceased person's usual medical practitioner. Form 2 would contain a brief summary of the deceased person's recent medical history and the chain of events leading to death. The doctor completing the form would have the option of expressing an opinion as to the cause of death. To be eligible to complete Form 2, a doctor should be registered in the UK and have been in practice for four years since qualification. (July 2003)	encouraged to set up new medical examiner services to replace existing death certification processes. The Notification of Deaths Regulations 2019 came into force, providing statutory categorisation of the circumstances in which a medical practitioner was required to report a death to the coroner. In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023. Regulations for the new death certification scheme are yet to be published.		
Improving patient safety	**16**	A statutory duty to complete Form 2 should be imposed: • in the case of a death occurring in hospital, upon the consultant responsible for the care of the deceased at the time of the death. The duty would be satisfied if the form were completed by a suitably qualified member of the consultant's clinical team or firm; and • in the case of a death occurring other than in a hospital, upon the general practitioner (rather than an individual general practitioner), the statutory duty would lie upon all principals in the practice until fulfilled by one of them.	The Coroners and Justice Act 2009 made provision for medical examiners to have a role in death certification. However, these provisions were not initially brought into force. From 1 April 2019, there was roll-out of a non-statutory system of medical examiners, whereby NHS trusts were encouraged to set up new medical examiner services to replace existing death certification processes. The Notification of Deaths Regulations 2019 came into force, providing statutory categorisation of the circumstances in which a medical practitioner was required to report a death to the coroner.	Coroners and Justice Act 2009. Notification of Deaths Regulations 2019.	

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		(July 2003)	In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023. Regulations for the new death certification scheme are yet to be published.		
Improving patient safety	**17**	The General Medical Council should impose upon doctors a professional duty to co-operate with the death certification system, requiring them to provide an opinion as to the cause of death on Form 2 in cases where it is appropriate to do so. A failure to co-operate should be a disciplinary matter. (July 2003)	The Coroners and Justice Act 2009 made provision for medical examiners to have a role in death certification. However, these provisions were not initially brought into force. From 1 April 2019, there was roll-out of a non-statutory system of medical examiners, whereby NHS trusts were encouraged to set up new medical examiner services to replace existing death certification processes. The Notification of Deaths Regulations 2019 came into force, providing statutory categorisation of the circumstances in which a medical practitioner was required to report a death to the coroner. In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023. Regulations for the new death certification scheme are yet to be published.	Coroners and Justice Act 2009. Notification of Deaths Regulations 2019.	

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			The General Medical Council is yet to impose any professional duty on doctors to cooperate with the death certification system.		
Improving patient safety	**18**	All deaths should be reported to the Coroner Service, which would take responsibility for certification of the death and for deciding whether further investigation was necessary. Deaths where the doctor completing Form 2 had expressed an opinion as to the cause of death would be considered for certification by a coroner's investigator after consultation with the deceased's family. All other deaths would go for further investigation by the medical coroner. (July 2003)	The Coroners and Justice Act 2009 made provision for medical examiners to have a role in death certification. However, these provisions were not initially brought into force. From 1 April 2019, there was roll-out of a non-statutory system of medical examiners, whereby NHS trusts were encouraged to set up new medical examiner services to replace existing death certification processes. The Notification of Deaths Regulations 2019 came into force, providing statutory categorisation of the circumstances in which a medical practitioner was required to report a death to the coroner. In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023. Regulations for the new death certification scheme are yet to be published.	Coroners and Justice Act 2009. Notification of Deaths Regulations 2019.	
	19	The Coroner Service would take primary responsibility for all post-death procedure. It would relieve other agencies of some of the	The Coroners and Justice Act 2009 made provision for medical examiners to have a role in death certification. However, these provisions were not initially brought into force.	Coroners and Justice Act 2009.	

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		responsibilities that they presently carry in connection with those procedures. (July 2003)	From 1 April 2019, there was roll-out of a non-statutory system of medical examiners, whereby NHS trusts were encouraged to set up new medical examiner services to replace existing death certification processes. The Notification of Deaths Regulations 2019 came into force, providing statutory categorisation of the circumstances in which a medical practitioner was required to report a death to the coroner. In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023. Regulations for the new death certification scheme are yet to be published.	Notification of Deaths Regulations 2019.	
	20	A proportion of all death certified by a coroner's investigator on the basis of the opinion of the Form 2 doctor should be selected randomly for fuller investigation at the discretion of the medical coroner. This process of random investigations would itself be the subject of audit. In addition, the Coroner Service should have the power to undertake targeted investigations, both prospective and retrospective. (July 2003)	The Coroners and Justice Act 2009 made provision for medical examiners to have a role in death certification. However, these provisions were not initially brought into force. From 1 April 2019, there was roll-out of a non-statutory system of medical examiners, whereby NHS trusts were encouraged to set up new medical examiner services to replace existing death certification processes. The Notification of Deaths Regulations 2019 came into force, providing statutory categorisation of the	Coroners and Justice Act 2009. Notification of Deaths Regulations 2019.	

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			circumstances in which a medical practitioner was required to report a death to the coroner. In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023. Regulations for the new death certification scheme are yet to be published.		
	21	A new certificate of cause of death should be designed for completion by a coroner's investigator or, where an investigation has been undertaken, by the medical coroner. If, in the future, it becomes possible to register a death on-line, registration could on many occasions be effected by the informant (with assistance) direct from the district coroner's office. (July 2003)	No roles of medical coroner or coroner's investigator were created.	Coroners and Justice Act 2009	
	22	Coroner's investigators should be trained to recognise the type of circumstances which make it appropriate for a death to be investigated by the medical coroner. The guidance given to investigators should permit flexibility and should be kept under constant review. (July 2003)	No roles of medical coroner or coroner's investigator were created.	Coroners and Justice Act 2009	
	23	In general, there should be an inquest only in a case in which the public interest requires a public investigation for reasons connected with the facts and circumstances of the individual case. There	Under section 6 of the Coroners and Justice Act 2009, a senior coroner who conducts an investigation into a person's death must as part of the investigation hold an inquest into the death, save if it is discontinued because the	Coroners and Justice Act 2009	

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		should be a few quite narrow categories in which an inquest would be mandatory. Otherwise, the decision whether the public interest required an inquest would be made by the judicial coroner and would be subject to appeal. (July 2003)	coroner is satisfied that the cause of death has become clear in the course of the investigation and the coroner thinks an inquest is not necessary to continue the investigation and other specified criteria apply.		
	24	In other cases, the product of the further investigation of a death would be a report (written by the medical or judicial coroner, occasionally by them both jointly) explaining how and why the deceased died. The report should be primarily for the benefit of the family of the deceased person, but should also be provided to any party or public body with a proper interest in its receipt. (July 2003)	Under section 4 of the Coroners and Justice Act 2009, where an investigation is discontinued because the cause of death becomes clear before inquest, the coroner must, if so requested, give a written explanation as to why the investigation was discontinued.	Coroners and Justice Act 2009.	
	25	Any recommendation made by a judicial or medical coroner, whether in the course of an inquest or a written report, should be submitted to the Chief Coroners. If they ratified it, they would then be responsible for taking it forward at a high level, first by submitting it to the appropriate body and then by pursuing that body until a satisfactory response has been received and action taken. (July 2003)	All prevention of future death reports and responses to them must be sent to Chief Coroner, who may publish these or summaries to them.	Coroners (Investigations) Regulations 2013.	
	26	The framework for the investigative procedures to be followed once a death has been identified as requiring investigation would be for the Board of the Coroner Service to determine. In any individual case, the course to be followed would be a matter	Implementation unknown.		

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		for the individual medical or judicial coroner to decide. (July 2003)			
	27	The judicial coroner should be given powers to order entry and search of premises and seizure of property and documents relevant to a death investigation. The medical coroner should be given powers to order the seizure of medical records and drugs. The judicial coroner should hear appeals from decisions of the medical coroner in relation to those powers of seizure. (July 2003)	Per Schedule 5 of the Coroners and Justice Act 2009, coroners have power to require evidence to be given or produced, but provisions relating to powers of entry, search and seizure are yet to come into force.	Coroners and Justice Act 2009	
	28	In cases where the medical cause of death is to be investigated, there should not be an automatic resort to autopsy. The medical coroner, who would have responsibility for establishing the cause of death, would have a variety of investigative tools at his/her disposal. If the medical coroner were considering an autopsy, the family of the deceased person would be informed and an explanation of why the autopsy was considered necessary would be given to them. There should be an opportunity for family members to advance objections. If the medical coroner were to decide nevertheless that an autopsy was necessary, the family should have a right to appeal the decision to the judicial coroner. In a case where the medical coroner concludes that the cause of death has been established and no further investigation is required, but the family is of the view that there should be an autopsy, there should be a right to make representations to the	Section 14 of the Coroners and Justice 2009 gives coroners the power to request post-mortem examination. In 2018, 39% of all deaths reported to coroners resulted in post-mortem examination, a decrease of 59% from 1997.	Coroners and Justice Act 2009 Chief Coroner's Guidance No. 32 Post-Mortem Examinations Including Second Post-Mortem Examinations[1] - Courts and Tribunals Judiciary (2019)	

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		medical coroner and to appeal to the judicial coroner. (July 2003)			
	29	In general, the medical coroner should seek to establish the cause of death to a high degree of confidence. However, in an appropriate case, it should be open to a medical coroner, provided that s/he has satisfied him/herself that there is no other reason why the death should be investigated further, to certify the cause of death on the balance of probabilities. In some case, it might be appropriate for the medical coroner to certify that the death was due to 'unascertained natural disease process'. However, such a cause should not be certified without toxicological screening of a blood or urine sample. The medical coroner should be permitted, in an appropriate case, to certify that a death was due to 'old age'. (July 2003)	The role of medical coroner was not created.	Coroners and Justice Act 2009	
	30	Disposal of the body of a deceased person whose death is being investigated by the Coroner Service should be permitted as soon as the body has been identified and a decision has been taken that it will not be required for further investigations. If the medical coroner is satisfied that the cause of death is known, but the investigation into the death is not yet complete in other respects, s/he should inform the family and the register office of that cause of death. If there remains any uncertainty about the cause of death, and that uncertainty cannot be resolved until the circumstances have been fully	Implementation unknown.		

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		investigated, the medical coroner should, where possible, provide the register office with a provisional cause of death. (July 2003)			
	31	Judicial coroners who have to conduct inquests should be relieved of the day-to-day responsibility for the pre-inquest investigation. They should direct the investigation, but responsibility for the collection of evidence should devolve onto a legally qualified person in the regional office. The judicial coroner should also have the assistance of that person or, in the more complex cases, counsel to the inquest, who would present the evidence and call the witnesses. (July 2003)	The Coroners and Justice Act 2009 permits coroners to delegate administrative functions to their officers and other support staff.	Coroners and Justice Act 2009.	
	32	If criminal proceedings have been commenced, there should be no need for an inquest to be opened and adjourned, as is the present practice. If the proceedings resulted in a conviction, the medical coroner would usually need to do no more than write a report recording the fact of the conviction, the cause of death and the brief circumstances of the death. In a rare case, a public interest issue might arise, in which case an inquest would be appropriate. If the proceedings led to acquittal, the death would be referred to the judicial coroner for inquest. (July 2003)	Sections 1 and 2 of the Coroners and Justice Act 2009 provide for a scheme whereby investigations are opened and then suspended on commencement of criminal proceedings, with exceptions to the need to suspend the investigation where a prosecuting authority informs it has no objection to the investigation continuing or the coroner thinks there is an exceptional reason for not suspending the investigation.	Coroners and Justice Act 2009	
	33	If any other agency (such as the Health and Safety Executive) were to investigate a death, the medical	Implementation unknown		

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		coroner would take no action, other than that necessary to establish the cause of death. When the other agency's investigation was complete, its report, together with the result of the medical coroner's investigation into the cause of death, would be sent to the judicial coroner. The judicial coroner would then decide whether any further investigation was required or whether an inquest should be held. If no inquest were to be held, the judicial coroner would write a report. (July 2003)			
Improving patient safety	**34**	Deaths which were, or might be, caused or contributed to by medical error or neglect should be investigated by the Coroner Service. Doctors should not be treated any differently from others whose errors led to death. At present, it appears that many cases of medical error and neglect are not reported to or investigated by coroners. The coroner's conclusions would not be determinative of civil liability. The Coroner Service should study the system of identifying and investigating cases of potential medical error being developed in Victoria, Australia, with a view to introducing something of a similar nature in this country. (July 2003)	Implementation unknown.		
Improving patient safety	**35**	Cases of possible medical error or neglect should be investigated initially by the medical coroner. If, following that investigation, it appeared to him/her that the death might have been caused or contributed to by medical error or neglect, the case should be referred to the regional coroner's office	The role of the medical coroner was not created.	Coroners and Justice Act 2009.	

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		for investigation by the regional medical coroner and judicial coroner. (July 2003)			
Improving patient safety	**36**	Cases of medical error or neglect transferred to the regional coroner's office would be investigated under the direction of a legally qualified person. There should be a small team of coroner's investigators at every regional office who can develop expertise in medical cases. Appropriate expert opinion would be obtained. Further ideas for the investigation of more complex medical cases should be considered with a view to a proper system of investigation being devised. (July 2003)	Implementation unknown.		
	37	All autopsies should be carried out to the standards recommended by the Royal College of Pathologists in its document 'Guidelines on autopsy practice', published in September 2002. The content of a properly conducted autopsy should be formally recognised, possibly by the production of a code of practice with statutory force. Pathologists should be provided with improved background information about the deceased person's medical history and the circumstances of the death so that they can interpret their findings in context. They should be free to carry out whatever special examinations they consider necessary for the completion of a thorough and accurate autopsy report, provided that there is proper medical justification for the conduct of those examinations. (July 2003)	Implementation unknown.		

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	38	Greater use should be made of toxicology in the investigation of deaths of which the cause is not immediately apparent. It should be the aim of medical coroners to move towards the use of toxicology in virtually all autopsies and in some cases where no autopsy is conducted. (July 2003)	Implementation unknown.		
	39	It should be possible for a medical coroner to authorise a partial autopsy. Any limitation would have to be very clearly defined and would have to be subject to the stipulation that, if the pathologist needs to go beyond what has been authorised, in order to reach a satisfactory conclusion as to the cause of death, s/he should be free to do so. (July 2003)	According to the Chief Coroner's Guidance, post-mortem examinations can take many forms, including external examination of the body, toxicology tests, tests on organs and tissue samples, CT/MRI scanning and/or full internal invasive examination.	Chief Coroner's Guidance No. 32 Post-Mortem Examinations Including Second Post-Mortem Examinations[1] - Courts and Tribunals Judiciary (2019)	
	40	Guidance on the issue of retention of organs and tissues following a coroner's autopsy will have to be provided for coroners by the Coroner Service. The medical coroner must have the power to order retention of organs and tissues if such retention is necessary for the purpose of his/her investigation. Families should have the same rights to object and appeal as in respect of an autopsy. (July 2003)	The Human Tissue Authority published its Code of Practice for post-mortem examinations in July 2006.	Code of Practice - Post mortem examination, Human Tissue Authority, July 2006	
	41	There are strong arguments to suggest that the criminal justice system and the Coroner Service would both be well served by a pathology service (including both forensic pathologists and those	No national pathology service appears to have been created.		

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		histopathologists who conduct most coroners' autopsies) which operated under the auspices of a Special Health Authority. If such a pathology service were to establish regional 'centres of excellence', this would fit well with the Inquiry's proposal for regional coroner's offices. (July 2003)			
Improving patient safety	**42**	There should be a statutory duty on any 'qualified' or 'responsible' person to report to the Coroner Service any concern relevant to the cause or circumstances of a death of which s/he becomes aware in the course of his/her duties. The duty should be to report as soon as practicable any information relating to a death believed by that person to be true and which, if true, might amount to evidence of crime, malpractice or neglect. (July 2003)	The Notification of Deaths Regulations 2019 imposes duties on registered medical practitioners to notify the relevant senior coroner of a person's death if certain circumstances apply.	The Notification of Deaths Regulations 2019.	
	43	All relevant employers should encourage their employees to report any concerns relating to the cause or circumstances of a death of which they become aware in the course of their duties. Employers should ensure that such reports are made to them are passed on to the appropriate quarter without delay and without any possibility of the reporter being subject to criticism or reprisal. (July 2003)	Implementation unknown.		
	44	The Coroner Service should seek to educate the public about the functions of the Service and, at the	The Ministry of Justice published a Guide to Coroner Services for Bereaved People in February 2014. The	Guide to coroner services (2014, last	

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		same time, encourage members of the public to report any concerns about a death. (July 2003)	Guide, however, focuses on explaining the coronial process once an investigation into a death has been commenced.	updated 28 January 2020)	
	45	There should be systematic audit of every function of the medical and judicial coroners and their investigators, save for those relating to the correctness of the decisions reached by the coroners. (July 2003)	Provision for inspection of the coroner system, contained within section 39 of the Coroners and Justice Act 2009, was never brought into effect and subsequently repealed in September 2012.	Coroners and Justice Act 2009.	
	46	Any decision made by a medical or judicial coroner would be subject to judicial review. However, a quicker and cheaper means of appeal should be provided, whereby decisions of the coroners that are wrong in law, plainly wrong on the facts, fail to set out the facts found or fail to give reasons for the conclusions can be set aside. The Chief Judicial Coroner should decide such appeals, if appropriate with the Chief Medical Coroner acting as medical adviser. From his/her decision, there should be a statutory right of appeal to the Divisional Court on a point of law only. (July 2003)	The right to appeal to the Chief Coroner, contained within section 40 of the Coroners and Justice Act 2009, was never brought into effect and subsequently repealed in February 2012.	Coroners and Justice Act 2009.	
	47	In the short term, changes to existing systems should be made. In particular, the cremation certification procedures should be strengthened. A variety of steps could be taken to improve practices in coroner's offices. (July 2003)	Implementation unknown.		

(c) The Fourth Report of the Shipman Inquiry (15 July 2004)

The Shipman Inquiry: Fourth Report					
Type of Recommendation	No.	Details of Recommendation	Implementation	Source	Extent of Implementation
Inspection Arrangements					
	1	A controlled drugs inspectorate should be created, comprising small multidisciplinary inspection teams, operating regionally but coordinated nationally. Each team would include pharmacists, doctors, inspectors and investigators, at least some of whom would have a law enforcement background. The inspectorate would be responsible for inspecting the arrangement in pharmacies, dispensaries and surgeries, as to both the safe keeping of stocks of controlled drugs and the maintenance of controlled drugs registers and other records. It could be responsible for the supervised destruction of controlled drugs. The inspectorate would also be responsible for the monitoring of the prescribing of controlled drugs by means of examination of prescribing analysis and cost (PACT) data, which would include information derived from NHS and private prescriptions and requisitions. It might be responsible for the issue of special controlled drug prescription pads. If thought appropriate it might also assume many of the inspecting and other functions currently performed by Home Office drugs inspectors. Inspectors and investigators would require access to background information about a doctor or pharmacist under	In its December 2004 response, the Government agreed with the recommendation for creation of a controlled drugs inspectorate in in principle. The Government said it proposed to strengthen and coordinate existing arrangements for monitoring and inspection through local networks centred on a named officer in each primary care trust. This would involve a corresponding duty of collaboration on other local agencies. Staff involved in this work would include primary care trust prescribing advisors and clinical governance leads; Royal Pharmaceutical Society of Great Britain inspectors; inspectors from the Healthcare Commission and the Commission for Social Care Inspection; and police officers with appropriate skill. The Government said the new monitoring and inspection regime would cover pharmacies, dispensaries, surgeries, hospitals and the private healthcare sectors. Local NHS organisations would be responsible for ensuring that all destructions of controlled dugs were appropriately witnessed and recorded. Audit tools would be devised centrally but applied locally by primary care trusts or hospital clinical governance leads, drawing on information	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	

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		scrutiny. There must be the facility to investigate expertly any irregularities or unusual features discovered as the result of such inspection and monitoring. (July 2004)	from both NHS and private prescriptions and requisitions and movement on stock movement. The Government agreed that partners in local networks would agree protocols for sharing of intelligence and for access to information needed for investigations. The Government rejected the recommendation that a monitoring body be responsible for the issue of special controlled drug prescription pads. The Government rejected the recommendation that a monitoring body should assume inspection and other functions performed by Home Office drugs inspectors. The Home Office Drugs Inspectorate was to continue to issue licences and inspect manufacturers and wholesalers.		
Prescribing Rights of Medical Practitioners					
	2	A medical practitioner should be entitled to prescribe or administer controlled drugs only if s/he needs to do so for the purposes of the 'actual clinical practice' in which s/he is engaged. For the vast majority of doctors, the existence of otherwise of such a need will be obvious. A practitioner who wishes to prescribe controlled drugs may, where the need is not obvious, have to justify such need when applying for the issue of a special controlled drug prescription pad. (July 2004)	The Government agreed with this recommendation in principle. In its December 2004 response, the Government said that, as a minimum, eligibility to prescribe controlled drugs should be dependent on the prescriber being accredited with a license to practise, or its equivalent, by the appropriate professional or registration body. The Government stated that good practice guidance would be strengthened to make clear prescribers should not	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	

The Shipman Inquiry: Fourth Report					
			prescribe beyond the limits of their competence or experience.		
	3	It should be a criminal offence for a doctor to prescribe a controlled drug for him/herself, or to self-administer a controlled drug from his/her own or practice stock save in circumstances of emergency, which circumstances should be covered by an appropriately worded statutory defence. The doctor should be required to declare the position on the prescription. (July 2004)	The Government agreed with this recommendation in part. In its December 2004 response, the Government said it agreed that self-prescribing of controlled drugs except in emergency was inappropriate, but it would look to professional bodies to enforce this through professional guidance and sanctions. No criminal offence was created.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	
	4	When a GP has members of his/her immediate family on his/her list (which should happen only very rarely), s/he should inform his/her local primary care trust of the position. It should be unacceptable for a doctor to prescribe a controlled drug for an immediate family member who is not on his/her list, save in circumstances of emergency. In all cases where a doctor prescribes a controlled drug for a member of his/her immediate family, the doctor should be required to declare on the prescription his/her relationship to the patient and, if this is the case, that s/he is prescribing in an emergency. (July 2004)	The Government agreed with this recommendation in part. In its December 2004 response, the Government said it would work with professional bodies to strengthen and clarify existing professional guidance.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	
	5	The General Medical Council should make plain that it will be regarded as professional misconduct for a doctor to prescribe controlled drugs for anyone	The Government agreed with this recommendation in principle.	Safer management of controlled drugs: The Government's response to the	

The Shipman Inquiry: Fourth Report					
		with whom s/he does not have a genuine professional relationship. (July 2004)	In its December 2004 response, the Government said it would ask professional bodies to strengthen ethical guidance, defining what constitutes a genuine professional relationship and setting out the appropriate clinical behaviours which underpin good practice.	Fourth Report of the Shipman Inquiry, December 2004.	
Improving patient safety	**6**	A medical practitioner convicted or cautioned in connection with a controlled drugs offence should be under a professional duty to report the conviction or caution to the General Medical Council, which should immediately consider what, if any, interim action should be taken and should report the facts and its own action to the practitioner's employer or primary care trust. (July 2004)	In its December 2004 response, the Government agreed with this recommendation and said that the General Medical Council had already issued guidance to this effect.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	
Improving patient safety	**7**	The Government should commission an independent review and audit of the way in which the General Medical Council and primary care trusts are using their powers to restrict the rights of medical practitioners involved in controlled drugs offences to prescribe and administer controlled drugs. Only if satisfied that these powers are being properly exercised for the protection of the public should the Government allow the provisions of section 12 of the Misuse of Drugs Act 1971 to remain in abeyance or to be repealed. (July 2004)	The Government agreed with this recommendation in principle. In its December 2004 response, the Government said it had commissioned an independent review of primary care trust decisions, but that the General Medical Council already had transparent arrangements for both internal and external audit of its fitness to practise decisions. The Government said it proposed to take legislative powers to repeal section 12 of the Misuse of Drugs Act 1971, but would not apply them until assessment of the available information confirmed this to be appropriate. Section 12 remains in force.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	

The Shipman Inquiry: Fourth Report					
Improving patient safety	**8**	Whenever a restriction is placed on a doctor's prescribing powers, this information should promptly be made available (preferably by electronic means) to those who need to know it, especially pharmacists who require access to such information at all times. (July 2004)	The Government agreed with his recommendation. In its December 2004 response, the Government said in the short term this could be achieved by then arrangements for cascading alerts, but in future it might be possible to make the information available on a secure intranet site or prevent unauthorised prescribing via the GP prescribing system.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	
Prescriptions					
	9	A special printed form should be introduced for use when prescribing a controlled drug, whether within the NHS or on a private basis. Pads of such forms should be supplied only to doctors who need to prescribe such drugs in the course of their clinical practice. For the time being, these forms should be completed by hand, to the extent required by the Misuse of Drugs Regulations 2001. However, prescribers should be encouraged, where practicable, to print the prescribing information on the prescription form using a computer and to copy the information by hand. The existing handwriting requirements should not be repealed until Government is satisfied, by the conduct of pilot schemes, that the arrangements for computer generation and/or transmission of controlled drug prescriptions are sufficiently secure. (July 2004)	In its December 2004 response, the Government rejected the recommendation for the introduction of special pads. The Government's view was that such would inconvenience prescribers and risk borrowing of pads. The Government rejected any distinction in pads for prescribers who do and who do not ever need to prescribe controlled drugs. The Government proposed to move as quickly as feasible to electronic generation of controlled drug prescriptions. The Government rejected the recommendation for prescribers to be encouraged to print the prescribing information on the prescription from using a computer and to copy the information by hand. The Government said it would seek further assurance that existing systems have adequate security features before allowing electronic transmission of prescriptions.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	

The Shipman Inquiry: Fourth Report					
	10	The special form should be in such format as will enable the Prescription Pricing Authority to scan the prescribing information into its database so as to permit subsequent analysis and monitoring. (July 2004)	The Government agreed with this recommendation in principle. In its December 2004 response, the Government said that the current standard prescription form was already suitable for scanning of additional information. In the longer term, information would be captured from electronic transmission of prescriptions.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	
	11	The special form should show the General Medical Council registration number of the medical practitioner to whom the pad of forms has been issued. No other practitioner should be permitted to use it. The form should require the prescriber to indicate whether the prescription has been issued under the NHS or privately. Each prescription would have its own unique identification number. (July 2004)	The Government agreed with this recommendation in principle. Future systems would use a 12-digit code to uniquely identify all prescribers, their practice and primary care trust. Controls on computers normally prevent practitioners from using the codes of other practitioners, and private prescribers would be required to use a similar but distinct form.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	
	12	The special form should provide the prescriber with a space in which to record a brief description of the condition for which the controlled drug has been prescribed. Prescribers should be expected, as a matter of good practice, to ask patients to consent to the provision of this information. (July 2004)	In its December 2004 response, the Government rejected the recommendation of a space in the form in which to record a brief description of the condition. It said the patient care record would provide a better solution in the longer term. The Government agreed in principle, in the context of the patient care record, that prescribers should be expected to ask patients to consent to the provision of this information, but stated it must be respected that there may be good reasons for refusal of consent.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	

The Shipman Inquiry: Fourth Report					
	13	Consideration should be given to requiring that the patient's NHS number or some other patient-specific identifier should be included on the special form. (July 2004)	The Government agreed with this recommendation. In its December 2004 response, the Government said that implementation should be straightforward once prescriptions for controlled drugs could be generated from the practice system.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	
	14	The amount of a controlled drug that can be dispensed on a single prescription should be limited to a supply sufficient to last 28 days. This restriction would not apply to drugs in Schedule 5 to the Misuse of Drugs Regulations 2001. (July 2004)	The Government agreed in principle with this recommendation, though it said in exceptional circumstances a supply of more than 28 days might be justified.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	
	15	The duration of validity of a prescription for controlled drugs should be limited to 28 days. This restriction would not apply to drugs in Schedule 5 to the Misuse of Drugs Regulations 2010. (July 2004)	The Government agreed with this recommendation. In its December 2004 response, the Government said a statutory 28-day limit would be introduced. However, prescribers would be allowed to extend the 28-day validity for prescriptions of short duration of supply, by endorsing the prescription. Good practice guidance would define the (exceptional) circumstances in which this could be justified.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004.	
	16	When computer generated prescriptions are in general use for controlled drugs and when the electronic transmission of prescriptions is introduced, the software should be so designed as	The Government agreed with this recommendation.	Safer management of controlled drugs: The Government's response to the	

The Shipman Inquiry: Fourth Report					
		to ensure that both the time of issue of a prescription and the time at which it is dispensed are recorded. (July 2004)	In its December 2004 response, the Government said it would in due course legislate to make this mandatory.	Fourth Report of the Shipman Inquiry, December 2004.	
Safe Custody and Record Keeping for General Practitioners					
	17	The purchase of all stocks of controlled drugs for practice use should follow a procedure that is capable of being monitored. The same form recommended for use when prescribing controlled drugs should also be used when ordering controlled drugs on requisition. The forms should be sent to the Prescription Pricing Authority for entry into its database so that all purchases of controlled drugs by any doctor can be monitored. (July 2004)	The Government agreed with this recommendation, subject to further work on feasibility and cost.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004	
	18	GPs who keep a stock of Schedule 2 controlled drugs should be required (as now) to keep a controlled drugs register and to observe existing safe custody requirements. They should be permitted to keep the controlled drugs register in electronic form. The controlled drugs register should provide for the keeping of a running stock balance for each drug stocked. Each GP who is either a principal in or employed by a practice that keeps controlled drugs for practice use should be under a legal obligation to comply with the terms of a standard operating procedure devised or approved either by the primary care trust with which the practice contracts or, if and when a controlled	In its December 2004 response, the Government agreed in principle with the recommendation that GPs keeping controlled drugs should maintain a controlled drugs register. Primary care providers would be required to make an annual declaration to the primary care trust as to whether they kept stocks of controlled drugs and of any special circumstances. Th Government said it would amend the Misuse of Drugs Regulations 2001 to allow electronic controlled drug registers as well as for controlled drug registers to provide for the keeping of a running stock balance for each drug stocked. The amendment came into force on 14 November 2005.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004	

The Shipman Inquiry: Fourth Report					
		drugs inspectorate is set up, by that body, the standard operating procedure should specify, among other things, the frequency with which the stock must be checked. Adherence to such standard operating procedures should be mandatory and subject to regular inspection. Any doctor working as a locum should be under an obligation either to comply with the practice standard operating procedure or to make his/her personal arrangements to provide Schedule 2 drugs and to accept responsibility for keeping the necessary controlled drugs register. The Healthcare Commission (or, if it comes into being, the controlled drugs inspectorate) should be responsible for approving standard operating procedures for GPs in private practice and for ensuring compliance. Advice as to compliance and best practice should be issued nationally and should also be available from primary care trust officers in the course of the annual clinical governance visit or review. (July 2004)	The Government agreed that all healthcare providers holdings stocks of controlled drugs should comply with an agreed standard operating procedure. It said it would work with the Healthcare Commission to issue model standard operating procedures. For NHS primary care providers, the procedure would be agreed by the relevant Named Officer in the primary care trust in which the provider was located. The Government agreed that the content of standard operating procedures would include arrangements for checks on stocks/reconciliation against the running balance in the controlled drug register as well as arrangements for safe custody of registers and access by staff. Adherence to standard operating procedures would be monitored and reinforced through normal clinical governance processes. The Government also agreed that the Healthcare Commission should be responsible for approving standard operating procedures for GPs in private practice and for ensuring compliance.		
	19	When the new arrangements for the provision of out of hours services come into effect, primary care trusts should establish protocols governing responsibility for the provision of Schedule 2 drugs and for the keeping of any controlled drugs register. I recommend the use of an appropriate standard operating procedure. (July 2004)	The Government accepted this recommendation. In its December 2004 response, the Government said that guidance on the new out of hours services was in preparation and would include suitable reference to the need for safe management of controlled drugs and compliance with relevant legislation.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman	

The Shipman Inquiry: Fourth Report					
				Inquiry, December 2004	
Controlled Drugs in the Pharmacy					
	20	There should be some relaxation of the strict requirement that a pharmacist is not permitted to dispense a controlled drug prescription unless there is full compliance with every technical requirement of the Misuse of Drug Regulations 2001. Where the defect is only technical and the pharmacist is confident that the intention of the prescriber is clear, and is willing to accept professional responsibility for dispensing the prescription in the form in which it is presented, s/he should the discretion to amend the prescription, to correct the technical defect and to dispense the drugs. (July 2004)	The Government agreed with this recommendation. In its December 2004 response, the Government said it would amend the Misuse of Drugs Regulations 2001 to allow pharmacists or dispensers to amend the prescription where there is a technical error and where the prescriber's intention is clear. Amended with effect from 7 July 2006.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004	
	21	In the case of a controlled drug supply that must be recorded in the pharmacy controlled drugs register, a pharmacist should be required to ask the name and address of the person collecting the drugs, unless that information is already known to him/her. If the pharmacist does not know the person, s/he should also ask the person collecting the drugs to produce some form of personal identification. The name and address and a note of the form of identification provided should be recorded in the controlled drugs register unless the collector is personally known to the pharmacist, in which case s/he should record that fact. If no identification is	The Government agreed with this recommendation. In its December 2004 response, the Government said it would amend the Misuse of Drugs Regulations 2001 to require dispensers to ask for this information, making it clear that a dispenser who users their discretion to make a supply in the absence of identification is not committing an offence. Amended with effect from 7 July 2006	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004	

The Shipman Inquiry: Fourth Report					
		provided, the pharmacist should have discretion to supply or withhold the drugs and, if the drug is supplied, should record the fact that no identification was provided. (July 2004)			
	22	Any healthcare professional, acting in his/her professional capacity, presenting a prescription or requisition for a controlled drug, the supply of which must be recorded in the pharmacy controlled drugs register, should, if not known to the pharmacist, be required to provide identification, preferably his/her professional registration card. The relevant information should be recorded in the controlled drugs register. (July 2004)	The Government agreed with this recommendation. In its December 2004 response, the Government said it would amend the Misuse of Drugs Regulations 2001 to require dispensers to seek this information and to require it to be recorded in the controlled drug register. If the healthcare professional is unable to provide formal ID, the pharmacist would have discretion to supply the controlled drug after seeking any corroborative information. Regulation 16 was amended with effect from 7 July 2006.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004	
	23	Any person collecting controlled drugs in Schedules 3 and 4 from the pharmacy should be required to write and sign his/her name on the back of prescription form. (July 2004)	The Government agreed with this recommendation. In its December 2004 response, the Government said further consideration was needed on how to achieve an equivalent result when electronic transmission of prescriptions was introduced.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004	
	24	Pharmacies should be permitted to keep their controlled drugs register in electronic form. (July 2004)	The Government agreed with this recommendation. In its December 2004 response, the Government said it would amend the Misuse of Drugs Regulations 2001 to this	Safer management of controlled drugs: The Government's response to the	

The Shipman Inquiry: Fourth Report					
			effect and give notice that electronic controlled drug registers would in due course become mandatory. The amendment came into force on 14 November 2005. The Regulations still permit the keeping of non-electronic registers.	Fourth Report of the Shipman Inquiry, December 2004	
	25	The keeping of a running balance in pharmacy controlled drugs registers should henceforth be regarded as good practice. The Home Office should make its view on this clear to pharmacists, and the Royal Pharmaceutical Society of Great Britain should publicise the new position. When electronic controlled drugs registers have come into general use, the keeping of such a balance should be made obligatory. (July 2004)	The Government agreed with this recommendation. In its December 2004 response, the Government said it would clarify or amend the Misuse of Drugs Regulations 2001 to make clear that controlled drug register may include a running balance and give notice of its intention to make a further amendment to the inclusion of a running balance a mandatory requirement.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004	
	26	The name and professional registration number of the prescriber should be entered into the controlled drugs register, as should the name of the pharmacist responsible for supplying controlled drugs to a patient or his/her representative. (July 2004)	The Government agreed with this recommendation in principle. In its December 2004 response, the Government said it would clarify or amend the Misuse of Use Drugs Regulations 2001 to make clear that this information could be entered into the controlled drugs register and make a further amendment to make this mandatory once electronic transmission of prescriptions is in common use. Regulation 20 was amended with effect from 14 November 2005 requiring each entry in the controlled drugs record to be "*attributable*" and capable of being audited.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004	

The Shipman Inquiry: Fourth Report					
	27	The current requirement that a pharmacy controlled drugs register be kept for two years should be amended and the period should be extended to seven, or possibly, ten years. When electronic records are used, it should be possible (and it may be desirable for controlled drugs registers to be kept even longer. (July 2004)	The Government agreed with this recommendation in principle. In its December 2004 response, the Government said that once electronic controlled drug registers were in common use, it would require pharmacies and dispensing practices to keep secure copies for up to 11 years. This amendment appears not have been made.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004	
Improving patient safety	**28**	The Royal Pharmaceutical Society of Great Britain should provide guidance to its members as to the information and advice to be given to patients and their representatives when receiving a supply of a controlled drug. This should usually comprise an accurate description of the controlled drug prescribed and advice about the need to keep the drug safe because of the risk of diversion. Patients and their representatives should be advised to return unused drugs to the pharmacy. This information and advice should be given both orally and in writing. (July 2004)	The Government agreed with this recommendation in principle. In its December 2004 response, the Government said it intended to mount a campaign about the need for safe storage and disposal of all medicines. The Government said it would promote informed dialogue between patients and healthcare professionals through guidance and education.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004	
Controlled Drugs in the Community					
	29	Pharmacists should be required to prepare a statutory patient drug record card to accompany every supply of injectable Schedule 2 drugs leaving the pharmacy. This should record the form and amount of the drug prescribed, the form and amount of the drug dispensed and the dosage	The Government agreed with this recommendation in principle. In its December 2004 response, the Government said it did not see the need for a master patient drug record card, but instead considered it would be more practicable for healthcare professionals to maintain a running balance on	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman	

The Shipman Inquiry: Fourth Report					
		instructions as they appear on the prescription. (July 2004)	the patient drug record card. The Government said it would pilot a system based on these proposals.	Inquiry, December 2004	
	30	The healthcare professionals who administer such Schedule 2 injectable drugs should be obliged to enter every administration and new supply of such a drug on a master patient drug record card and should keep a running balance of the remaining stock. The destruction of any unused Schedule 2 injectable drugs should be recorded on the patient drug record card, wherever it takes place. After the death of the patient or when the time has come when injectable drugs are no longer required by him/her, the completed patient drug record card should be sent to the primary care trust to which the patient's GP is contracted. The patient drug record cards should be examined for anomalies and then married up with the patient's GP records. The controlled drugs inspectorate (if and when there is one) might carry out an occasional audit of patient drug record cards. (July 2004)	The Government agreed with this recommendation in principle. In its December 2004 response, the Government said it did not see the need for a master patient drug record card, but instead considered it would be more practicable for healthcare professionals to maintain a running balance on the patient drug record card. The Government said it would pilot a system based on these proposals. The Government said it considered a good practice for healthcare professionals to return controlled drugs for destruction rather than to destroy them in situ. Where destruction in the home was considered necessary, the Government would require it to be witnessed in the patient drug record card by a second signatory. The Government agreed that the completed patient drug record card should be returned for analysis and reconciliation, but considered this should be done centrally rather than by the primary care trust.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004	
	31	Consideration should be given to changing the law so that all controlled drugs would become the property of the Crown on the death of the patient for whom they were prescribed. (July 2004)	The Government rejected this recommendation. The Government said it was not persuaded that a change in the law was necessary or would make it easier for	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman	

The Shipman Inquiry: Fourth Report					
			healthcare professionals to remove unwanted controlled drugs after the death of a patient.	Inquiry, December 2004	
	32	There should be increased formality attaching to the destruction of injectable Schedule 2 controlled drugs dispensed for administration in the community. Their destruction and their removal from the home of the patient should be properly recorded and witnessed. The classes of person lawfully entitled to undertake or witness destruction should include doctors, pharmacists, nurses, suitably trained law enforcement officers or primary care trust officers, and inspectors of any new controlled drugs inspectorate. (July 2004)	The Government agreed with this recommendation. In its December 2004 response, the Government said it would amend the Misuse of Drugs Regulations 2001 to require healthcare professionals to record on the patient drug record card, and have witnessed, any supply of injectable controlled drugs which they remove from the patient's home or destroy at the end of a course of treatment. The Government said it would also amend the Misuse of Drugs Regulations 2001 to make clear that healthcare professionals may lawfully remove unwanted controlled drugs. Regulation 27 was amended with effect from 16 August 2007. The Government said it would undertake a review of the classes of person entitled to undertake or witness destruction.	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004	
	33	It should be the responsibility of primary care trusts to ensure that suitable arrangements are in place for the disposal of controlled drugs. (July 2004)	The Government agreed with this recommendation in principle. In its December 2004 response, the Government said the Department of Health would issue guidance requiring primary care trusts to make suitable arrangements to ensure that any unwanted controlled drugs, and associated patient drug record cards, are recovered from patient's homes after the patient's death or the end of treatment and returned to a community pharmacy or dispensing practice	Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry, December 2004	

The Shipman Inquiry: Fourth Report					
			dispensary. Primary care trusts would also ensure that pharmacies and dispensaries have arrangements for disposing of controlled drug waste which minimise the risk of diversion and comply with waste regulation.		

(d) The Fifth Report of the Shipman Inquiry (9 December 2004)

The Shipman Inquiry: Fifth Report					
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
Handling Complaints and Concerns					
Improving the ability to raise complaints and concerns	**1**	I endorse the provision contained in the draft National Health Service (Complaints) Regulations (the draft Complaints Regulations), whereby patients and their representatives who wish to make a complaint against a GP will be permitted to choose whether to lodge that complaint with the GP practice concerned or with the local primary care trust. I recommend that the time limit for lodging a complaint be extended from six to twelve months. (December 2004)	In the February 2007 Safeguarding Patients report, the Government accepted that the time limit for complaining should be extended from 6 to 12 months. Otherwise, the recommendation was accepted subject to further consultation. The Department of Health said it was "*minded*" to amend the complaints regulations to enable patients to make complaints directly to the local primary care trust, although in such circumstances patients would generally not be able to maintain anonymity. Implemented in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.	

The Shipman Inquiry: Fifth Report					
Improving the ability to raise complaints and concerns	**2**	Steps should be taken to improve the standard of complaints handling by GP practices. (December 2004)	The Government accepted the recommendation. The Department of Health published generic good practice guidance applicable in primary care. The Department of Health also said it was working to establish a national network of local complaints managers to enable complaints staff to share best practice and to provide mutual support.	Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**3**	Draft regulation 30 of the draft Complaints Regulations, which would require GP practices to provide primary care trusts with limited information about complaints received by the practice at intervals to be specified by the primary care trust, should be amended. GP practices should be required to report all complaints to the primary care trust within, say, two working days of their receipt. The report should comprise the original letter of complaint or, if the complaint was made orally, the practice's record of the complaint. The trust should log the complaint for clinical governance purposes and, if it considers that the complaint raises clinical governance issues, it should 'call in' the complaint for investigation. (December 2004)	The Government accepted the recommendation in principle, subject to further consultation. In the February 2007 Safeguarding Patients report, the Department of Health said it was "*minded*" to require practices to copy all complaints letters to the primary care trust within a set period. Primary care trusts would be required to maintain an oversight of all the complaints received by practice and to be prepared to investigate any patterns or trends of concern. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 required primary care providers to send a copy of its annual complaints report to the relevant primary care trust.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The Local Authority Social Services and National Health Service Complaints	

The Shipman Inquiry: Fifth Report					
				(England) Regulations 2009.	
Improving the ability to raise complaints and concerns	**4**	There should be statutory recognition of the importance of the proper investigation of complaints to the processes of clinical governance and of monitoring the quality of health care. (December 2004)	The Government accepted the recommendation. In the February 2007 Safeguarding Patients report, the Government referred to the pre-existing statutory duty of quality, which NHS organisations discharged by complying with better standards, including ensuring they had effective clinical governance processes in place. The Government said it would consider how this statutory responsibility could be further strengthened and extended to independent and third sector healthcare providers. The Government did not refer to ensuring statutory recognition of the importance of the proper investigation of complaints.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**5**	On receipt by a primary care trust of a complaint about a GP, a 'triage' (the first triage) of the complaint should be conducted by a member of the primary care trust's staff who is appropriately trained and experienced and has access to relevant clinical advice. The object of the first triage should be to assess whether the complaint arises from a purely private grievance or raises clinical governance issues. (December 2004)	The Government said it would discuss this with stakeholders as part of the formal consultation on a revised complaints framework, how to promote best practice in identifying the most serious complaints. In the February 2007 Safeguarding Patients report, the Government said that triaging cases into those involving "private grievance" and "clinical governance" issues had attraction, but was not always clear-cut.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

The Shipman Inquiry: Fifth Report					
				Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**6**	'Private grievance complaints' should be dealt with by appropriately trained primary care trust staff. The objectives in dealing with such complaints should be the satisfaction of the patient and, where possible, restoration of the relationship of trust and confidence between doctor and patient. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that triaging cases into 'private grievance' and 'clinical' governance issues was not always clear-cut. It said it believed that complaints not involving broader issues of patient safety should where possible be resolved by the GP practice, although on occasion an element of mediation by the primary care trust may be needed.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**7**	'Clinical governance complaints' should be investigated with the dual objectives of patient protection and satisfaction and of fairness to doctors. They should be referred for a further triage (the second triage) to a small group comprising two or three people – for example, the Medical Director or Clinical Governance Lead, a senior non-medical officer of the primary care trust and a lay member of the primary care trust Board. The object of the second triage should be to decide whether the complaint is to be investigated by or on behalf of the	In the February 2007 Safeguarding Patients report, the Government said its view was that clinical governance complaints should be investigated by the primary care trust with said dual objectives. The Government also agreed that early decisions were needed on how potential concurrent investigations should be handled. The Government said it believed that, so far as is practicable in individual cases, there should be a single investigation, with the manager initially assigned to investigate required to identify from the outset the other	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

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		primary care trust or whether it should instead be referred to some other body, such as the police, the General Medical Council or the National Clinical Assessment Authority. (December 2004)	organisations that might have an interest. The Government also agreed with the proposed membership of triage groups but said it did not wish to be too prescriptive on this point.	Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**8**	The investigation of 'clinical governance complaints' should not be undertaken by primary care trust staff. Instead, groups of primary care trusts should set up joint teams of investigators, who should be properly trained in the techniques of investigation and should adopt an objective and analytical approach, keeping their minds open to all possibilities. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that it accepted this was a useful model which some primary care trusts had used to good effect, but did not intend to be prescriptive on the point.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving the ability to raise complaints and concerns	**9**	All 'clinical governance complaints' (save those which do not involve serious issues of patient safety and where the underlying facts giving rise to the complaint are clear and undisputed) should be referred to the inter-primary care trust investigation team. The objects of the investigation should be to reach a conclusion as to what happened and to set out the evidence and conclusions in a report which should go to the primary care trust with responsibility for the doctor. If the investigators are unable to reach a conclusion about what happened because there is an unresolved conflict of evidence, they should say so in their report. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said it agreed the importance of objective investigation by properly trained investigators. It said it would further develop guidance in relation to the investigation of complaints subject to formal consultation on a revised complaints framework.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**10**	On receipt of the investigation report, the primary care trust group which carried out the second triage should consider what action to take. It might be appropriate to refer the matter to another body, such as the General Medical Council or the National Clinical Assessment Authority. Alternatively, it might be appropriate for the primary care trust to take action itself, e.g. by invoking its list management powers. If the report of the investigation team is inconclusive, because of a conflict of evidence, the case should be referred to the Commission for Healthcare Audit and Inspection (now known as the Healthcare Commission), under a power which should be included in the amended draft Complaints Regulations when implemented. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said it agreed the need for a fair and transparent decision-making process, independent of original investigation. The government said it would issue further guidance on the processes to be adopted in primary care. The Government rejected the recommendation that, if an investigation is inconclusive, the case should be referred to the Healthcare Commission.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving the ability to raise complaints and concerns	**11**	Neither an intention on the part of the complainant to take legal proceedings, nor the fact that such proceedings have begun, should be a bar to the investigation by a NHS body of a complaint. In circumstances where the NHS body is taking disciplinary proceedings relating to the subject matter of the complaint against the person complained of, a complainant should be entitled to see the substance of the report of the investigation on which the disciplinary proceedings are to be based and should not merely be informed that the investigation of his/her complaint is to be deferred or discontinued. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said it agreed that intention to take legal proceedings or actually doing so ought not to bar investigation of a complaint, so long as further investigation by the NHS body did not prejudice such proceedings. The Government said it agreed in principle that information relating to the investigation of a complaint should be available. It said it would issue guidance on the point after further consultation.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**12**	In some circumstances, it may be necessary for a NHS body to defer or discontinue its own investigation of a complaint if the matter is being investigated by the police, a regulatory body, a statutory inquiry or some other process. However, a NHS body should never lose sight of its duty to find out what has happened and to take whatever action is necessary for the protection of the patients of the doctor concerned. It should also provide such information to the complainant as is consistent with the need, if any, for confidentiality in the public interest. The relevant provisions of the draft Complaints Regulations should be amended to reflect these principles. (December 2004)	In the February 2007 Safeguarding Patients report, the Government accepted this recommendation. Advice in relation to the same was issued in the Memorandum of Understanding between the Association of Chief Police Officers, the Department of Health and the Health and Safety Executive, as well as the Information Sharing Protocol between the General Medical Council, the Nursing and Midwifery Council, the Association of Chief Police Officers and the Crown Prosecution Service.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Memorandum of understanding: Investigating	

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				patient safety incidents involving unexpected death or serious untoward harm (Association of Chief Police Officers, Department of Health, and Health and Safety Executive, February 2006) Information sharing protocol between the General Medical Council, the Nursing and Midwifery Council, the Association of Chief Police Officers and the Crown Prosecution Service (July 2006)	
Improving the ability to raise complaints and concerns	**13**	The draft Complaints Regulations, when implemented, should include a power enabling primary care trusts to refer a complaint to the Healthcare Commission for investigation at any point during the first stage of the complaints procedures. Cases raising difficult or complex	In the February 2007 Safeguarding Patients report, the Government said it agreed that there might be a need to help healthcare organisations with more complex investigations. However, it rejected the need for an automatic right of referral of complex complaints to the Healthcare Commission. It would only be occasions where	Safeguarding Patients: The Government's Response to the recommendations of the Shipman	

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		issues or involving issues relating to both primary and secondary care might be referred to the Healthcare Commission for investigation at the time of the second triage, or later if the investigation by the inter-primary care trust investigation team raises more complex issues than were initially apparent. Referral to the Healthcare Commission should also take place in cases where an inter-primary care trust investigation team has found that it cannot reach a conclusion because there remain unresolved disputes of fact. The purpose of the referral would be for the Healthcare Commission to carry out any further necessary investigation and, if appropriate, to set up a panel to hear oral evidence about the facts in dispute and to decide where the truth lay. (December 2004)	investigation of performance issues indicated a deeper structural problem in the organisation it would be appropriate to alert the Healthcare Commission.	Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**14**	Complaints procedures in the private sector should be aligned as closely as possible with those in the NHS, so that a complainant who does not receive a satisfactory response to his/her complaint from a private sector body can proceed to a second stage of the complaints procedures to be conducted by the Healthcare Commission. (December 2004)	In the February 2007 Safeguarding Patients report, the Government accepted the recommendation in principle. The Government said it would work with the Healthcare Commission and representatives of independent and voluntary sectors towards this aim. The Government referred to the need for independent clinics and hospitals registered with the Healthcare Commission to have a policy for dealing with complaints.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving the ability to raise complaints and concerns	**15**	Concerns expressed about a GP by someone other than a patient or patient's representative (e.g. by a fellow healthcare professional) should be dealt with in the same way as patient complaints. Such concerns should be investigated (where necessary) by the inter-primary care trust investigation team or, in a case raising difficult or complex issues, by the Healthcare Commission. Consideration should be given to amending the relevant provisions of the draft Complaints Regulations to permit the Healthcare Commission to accept and investigate concerns referred to it by a primary care trust or other healthcare body without the need for a reference from the Secretary of State for Health. (December 2004)	In the February 2007 Safeguarding Patients report, the Government agreed that concerns expressed about a GP by someone other than a patient should be dealt with in the same way as patient complaints. The Government rejected the recommendation that the Healthcare Commission should be given the power to accept and investigate concerns referred to it by a primary care trust.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**16**	Objective standards, by reference to which complaints can be judged, should be established as a matter of urgency. These standards should be applied by those making the decision whether to uphold or reject a complaint and by primary care trusts and other NHS bodies when deciding what action to take in respect of a doctor against whom a complaint has been upheld. When established, the standards by reference to which complaints are dealt with must fit together with the threshold by reference to which the General Medical Council will accept and act upon allegations, so as to form a comprehensive framework. (December 2004)	The Government agreed with the recommendation. In the February 2007 Safeguarding Patients report, the Department of Health said it would invite the Council for Healthcare Regulatory Excellence to lead work on protocols for NHS investigations, to include guidance for NHS complaints handlers on the standards for judging complaints and the thresholds at which they should consider referral to professional regulators.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving the ability to raise complaints and concerns	**17**	In order to ensure that, so far as possible, complaints and concerns about health care reach the appropriate destinations, there should be a 'single portal' by which complaints or concerns can be directed or redirected to the appropriate quarter. This service should also provide information about the various advice services available to persons who are considering whether and/or how to complain or raise a concern, including advice services for persons who are concerned about the legal implications of raising a concern. (December 2004)	The Government rejected this recommendation. In the February 2007 Safeguarding Patients report, the Government said that, while it agreed for the need for better support for patients who were unsure where to make a complaint, its preferred solution was to introduce standards so that bodies receiving a complaint could forward it to the right recipient and tell the complainant what they had done.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**18**	About two years after the Complaints Regulations come into force in their entirety, an independent review should be commissioned into the operation of the new arrangements for advising and supporting patients who wish to make a complaint. Any deficiencies identified by that review should be corrected. (December 2004)	In the February 2007 Safeguarding Patients report, the Government accepted the recommendation in principle and said it would link this with a planned review of the NHS redress scheme.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Disciplinary Procedures					

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Improving patient safety	**19**	The powers of primary care trusts should be extended so as to enable them to issue warnings to GPs and to impose financial penalties on GPs in respect of misconduct, deficient professional performance or deficient clinical practice which falls below the thresholds for referral to the General Medical Council or exercise of the primary care trust's list management powers. (December 2004)	In the February 2007 Safeguarding Patients report, the Government accepted the recommendation in principle and said it would discuss it with stakeholders as part of a broader review of the Performers List system.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
The Use of Prescribing Information as a Clinical Governance Tool					
	20	Steps should be taken to ensure that every prescription generated by a GP can be accurately attributed to an individual doctor. Only then will the data resulting from the monitoring of prescribing information constitute a reliable clinical governance tool. (December 2004)	In the February 2007 Safeguarding Patients report, the recommendation was accepted by the Government. GP prescribing numbers were subsequently introduced.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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	21	Regular monitoring of GPs' prescribing should be undertaken by primary care trusts. Special attention should be paid to the prescribing of controlled drugs. Doctors who have had a problem of drug misuse in the past or who are suspected of having a current problem should be subjected to particularly close scrutiny. When a restriction is placed on a doctor's prescribing powers, this information must be made available (preferably by electronic means) to those who need to know, especially pharmacists. (December 2004)	This recommendation was accepted by the Government. In the February 2007 Safeguarding Patients report, the Government referred to primary care trusts already routinely monitoring prescribing by GPs and other prescribers. The Government said it would invite the Royal College of General Practitioners to work with the NHS Information Centre on how such information could best be used to assure the quality of GP services. The Government also referred to a plan for information to be held on a secure intranet site.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Safer management of controlled drugs: The Government's response to the Fourth Report of the Shipman Inquiry	
The Use of Mortality as a Clinical Governance Tool					
Improving patient safety	**22**	The Department of Health must take the lead in developing a national system for monitoring GP patient mortality rates. The system should be supported by a well-organised, consistent and objective means of investigating those cases where	This recommendation was accepted by the Government. In the February 2007 Safeguarding Patients report, the Government referred to the development of a Primary Care Mortality Database, linking mortality data to primary care practices, by the NHS Information Centre and the Office of National Statistics. However, the Government expressed	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report	

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		a GP's patient mortality rates signal as being above the norm. (December 2004)	the view that practice-level mortality data on its own only had limited use for clinical governance purposes. It said it would further explore the point with stakeholders.	and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**23**	Every GP practice should keep a death register in which particulars of the deaths of patients of the practice should be recorded for use in audit and for other purposes. (December 2004)	This recommendation was accepted by the Government in principle. In the February 2007 Safeguarding Patients report, the Government said it would be taking the recommendation forward in consultation with the Royal College of General Practitioners, GP interests and other stakeholders.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**24**	Primary care trusts should undertake reviews of the medical records of deceased patients, either on a routine periodic basis (if resources permit) or on a targeted basis limited to those GPs whose performance gives rise to concern. (December 2004)	This recommendation was accepted by the Government in principle. In the February 2007 Safeguarding Patients report, the Government said it would be taking the recommendation forward in consultation with the Royal College of General Practitioners, GP interests and other stakeholders.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

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				Inquiries, February 2007.	
Appraisal in the Context of Clinical Governance					
Improving patient safety	**25**	The purpose of GP appraisal must be made clear. A decision must be taken as to whether it is intended to be a purely formative (i.e. educational) process or whether it is intended to serve several purposes: part formative, part summative (i.e. pass/fail) and/or part performance management. (December 2004)	This recommendation was accepted by the Government. In the February 2007 Safeguarding Patients report, the Government said that, in the future, appraisal for doctors would have a summative component and would form part of the revalidation process.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**26**	If appraisal is intended to be a clinical governance tool, it must be 'toughened up'. If that is to be done, the following steps will be necessary. Appraisers should be more thoroughly trained and should be accredited following some form of test or assessment. Appraisers should be trained to evaluate the appraisee's fitness to practise. GPs should be appraised by GPs from another primary care trust. Standards should be specified, by which a GP 'successfully completes' or 'fails' the appraisal. All appraisals should be based on a nationally agreed core of verifiable information supplied by the primary care	This recommendation was accepted by the Government. In the February 2007 Safeguarding Patients report, the Government said that, in the future, appraisal for doctors would have a summative component and would form part of the revalidation process. No further detail was given.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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		trust to both the appraiser and the appraisee. (December 2004)			
The Use by Primary Care Trusts of their List Management Powers					
Improving NHS culture and governance	**27**	The Family Health Services Appeal Authority (Special Health Authority) or its proposed successor, the NHS Litigation Authority, should collect and analyse information relating to the use made by primary care trusts of their list management powers. Such analysis would assist the Department of Health in providing guidance to primary care trusts about the types of circumstance in which they might properly use their powers. (December 2004)	This recommendation was rejected by the Government. In the February 2007 Safeguarding Patients report, the Government referred to the Family Health Services Authority as already publishing some relevant analyses and referred to evidence from the Sheffield School of Health and Allied Research which suggested primary care trusts seemed in general to be well informed. The Government considered it did not need to impose any additional reporting requirements on primary care trusts. The Government rejected encouraging wider use of reporting routes that avoided local organisations' own reporting systems, due to risk of important information about the incident not reaching the organisation concerned. NHS England were to consider how to make an online e-form more widely available and explore feasibility of online reports being fed back to trusts.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Practice Accreditation Schemes					
	28	The Government should consider the feasibility of providing a financial incentive for the achievement of GP practice accreditation by means of an accreditation scheme similar to that operated by the	In the February 2007 Safeguarding Patients report, the Government referred to the Royal College of General Practitioners developing proposals for a Primary Care Practice Accreditation Scheme, which the Government said	Safeguarding Patients: The Government's Response to the recommendations	

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		Royal College of General Practitioners in Scotland. (December 2004)	it was considering as part of its wider programme of system reform.	of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Support for Single-Handed and Small Practices					
	29	The policy of the Department of Health and of primary care trusts should be to focus on the resolution of the problems inherent in single-handed and small practices. More support and encouragement should be given to GPs running single-handed and small practices. In return, more should be expected of such GPs in terms of group activity and mutual supervision. The Department of Health should take responsibility for these initiatives. (December 2004)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said it would discuss the recommendation further with NHS and professional organisations.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
The Recruitment and Appointment of General Practitioners					
Improving patient safety	**30**	Primary care trusts should be willing and able to provide advice to GP practices on good recruitment practice and should also be willing to offer support in drafting job specifications and advertisements.	The Government accepted this recommendation in principle.	Safeguarding Patients: The Government's Response to the	

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		They should be prepared, if requested, to assist in sifting applications (if multiple applications are received) and in making the necessary checks on applicants before the interview stage, so as to exclude in advance any applicants who are unsuitable. However, this latter exercise may be too much of a burden for primary care trusts unless and until the Inquiry's recommendations for greater information to be placed on the General Medical Council's website and for the creation of a central database of information about doctors (see below) are implemented. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said it would discuss the recommendation further with NHS, professional and patient organisations.	recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**31**	A standard reference form should be developed for use in connection with appointments to GP practices. Primary care trusts should insist that a reference is obtained from the doctor's previous employer or primary care trust. In the case of a primary care trust, the reference should be signed by the Medical Director or Clinical Governance Lead. (December 2004)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said it would discuss the recommendation further with NHS, professional and patient organisations.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**32**	When recruiting a new member, GP practices should canvass and take account of the views of their patients about the kind of doctor the practice needs. (December 2004)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said it agreed that practices should be	Safeguarding Patients: The Government's Response to the recommendations	

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			responsible to the views of their patients in deciding how to develop their services, but ultimately that was a matter for the practices.	of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
General Practitioners' Personal Files					
Improving patient safety	**33**	Primary care trusts should keep a separate file for each individual GP on their lists. That file should hold all material relating to the doctor which could have any possible relevance to clinical governance. If a doctor moves from one primary care trust to another, the file (or a copy of it) should be sent to the new primary care trust. It might be helpful if the Department of Health were to establish national criteria for the content of the files to be kept by primary care trusts. (December 2004)	This recommendation was accepted by the Government in principle. In the February 2007 Safeguarding Patients report, the Government said it would take forward the recommendation in discussion with stakeholders.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
The Raising of Concerns					
Improving the ability to raise	**34**	Every GP practice should have a written policy, setting out the procedure to be followed by a	This recommendation was accepted by the Government in principle.	Safeguarding Patients: The	

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complaints and concerns		member of the practice staff who wishes to raise concerns, in particular concerns about the clinical practice or conduct of a healthcare professional within the practice. Staff should be encouraged to bring forward any concerns they may have openly, routinely and without fear of criticism. In the event that a member of the staff of a GP practice feels unable to raise his/her concern within the practice, s/he should be able to approach a person designated by the primary care trust for the purpose. The contact details of that person should appear in the written policy. The designated person should make him/herself known to all practice staff working in the primary care trust area. Primary care trusts should ensure, through training, that practice staff understand the importance of reporting concerns and know how to do so. (December 2004)	In the February 2007 Safeguarding Patients report, the Government proposed that all NHS organisations should have a written policy as described and said it would discuss with stakeholders how best to carry this forward. The Government also accepted in principle that an appropriate channel for concerns should be available where staff felt unable to raise them in the organisation in which they worked. The Government considered that the primary care trust or strategic health authority might have a role to play, and said it would explore this with stakeholders.	Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**35**	The written policy should contain details of organisations from which staff can obtain free independent advice. If the 'single portal' is created, in whatever form, the policy should set out contact details of that also. (December 2004)	The Government accepted this recommendation.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving the ability to raise complaints and concerns	**36**	The Healthcare Commission should require all private healthcare organisations to have a clear written policy for the raising of concerns. Steps should be taken to foster in the private sector the same culture of openness that is being encouraged in the NHS. (December 2004)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, it said it would consider how this could be best achieved in the new regulatory system to apply to healthcare providers. However, the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 made no mention of a requirement of a written policy and, in any event, only applied to private healthcare organisations if they provided healthcare under arrangements with an NHS body.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Local Authority Social Services and National Health Service Complaints (England) Regulations 2009	
Improving the ability to raise complaints and concerns	**37**	Consideration should be given to amending the Public Interest Disclosure Act 1998 in order to give greater protection to persons disclosing information, the disclosure of which is in the public interest. (December 2004)	The Government rejected this recommendation. In the February 2007 Safeguarding Patients report, the Government said it was not persuaded that change to the Public Interest Disclosure Act 1998 was necessary. The Government said it would instead work with NHS organisations to draw up protocols under the Act to provide equivalent protection for staff bringing concerns to the attention of the General Medical Council.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale	

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				and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**38**	Written policies setting out procedures for raising concerns in the healthcare sector should be capable of being used in relation to persons who do not share a common employment. (December 2004)	The Government accepted this recommendation.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**39**	There should be some national provision (probably a telephone helpline) to enable any person, whether working within health care or not, to obtain advice about the best way to raise a concern about a healthcare matter and about the legal implications of doing so. It might be possible to link this helpline with the 'single portal' previously referred to. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said it would discuss with strategic health authorities and primary care trusts the best way of providing a locally or regionally based helpline for health service staff or members of the public who want confidential advice about raising concerns.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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The Availability of Information about Doctors					
Improving patient safety	**40**	There should be a central database containing information about every doctor working in the UK. This should be accessible to the officers of NHS bodies and to accredited employers in the private sector, as well as to other bodies with a legitimate interest, such as the Healthcare Commission, the General Medical Council, the National Clinical Assessment Authority and the Department of Health. (December 2004)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Department of Health said it would discuss with stakeholders how the General Medical Council register could be enhanced to provide this resource.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**41**	The database would contain, or provide links to, information held by the General Medical Council, the Criminal Records Bureau and the NHS Counter Fraud and Security Management Service. It would also contain records of disciplinary action by employers, details of list management action by primary care trusts, any adverse reports following the investigation of a complaint, any adverse findings by a Healthcare Commission panel or by the Healthcare Ombudsman and details of any findings of negligence in a clinical negligence action and settlement of a clinical negligence claim above a pre-determined level of damages. It should also contain certain other information. Doctors would be	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Department of Health said it would discuss with stakeholders how the General Medical Council register could be enhanced to provide this resource.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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		able to access their own entries to check the accuracy of the information held. (December 2004)			
Improving patient safety	**42**	Private sector employers should be required to provide relevant information as a condition of registration with the Healthcare Commission. Deputising services should also be required to provide information and should be able to access the database through the relevant primary care trust. (December 2004)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Department of Health said it would discuss with stakeholders how the General Medical Council register could be enhanced to provide this resource.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**43**	Information about unsubstantiated allegations or concerns should not be included on the central database. Instead, the doctor's entry on the database should be flagged to indicate that confidential information is held by a named body. Access to that information would depend on who was asking for it and for what purpose and would have to be determined at a high level. (December 2004)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Department of Health said it would discuss with stakeholders how the General Medical Council register could be enhanced to provide this resource.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving patient safety	**44**	GPs should be required to disclose to the relevant primary care organisation the fact that a clinical negligence claim has been brought against them, the gist of the allegation made and, when the time comes, the outcome of the claim. A failure by a doctor to make full declarations to a primary care organisation as required by the National Health Service (Performers Lists) Regulations 2004 should be regarded as misconduct of sufficient gravity to warrant referral to the General Medical Council. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said it had discussed the proposal with the NHS Litigation Authority and the Medical Defence Unions. The Government said that there were significant issues with the recommendation and took the view, in light of these difficulties, that clinical negligence claims should only be reported to primary care trusts to maintain a broad overview of the pattern of complaints and concerns about the doctor and not with any presumption that the rate of claims is a reliable indicator of the quality of their practice. The Government said it would discuss the issues further with relevant stakeholders.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**45**	The General Medical Council should adopt a policy of tiered disclosure to apply to all persons seeking information about a doctor. (December 2004)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government referred to the General Medical Council as having already implemented a form of tired disclosure.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**46**	The first tier should relate to information which is relevant to the doctor's current registration status, together with certain information about his/her past	The Government accepted this recommendation.	Safeguarding Patients: The Government's	

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		fitness to practise history. First-tier information should be posted on the General Medical Council website and should also be disclosed to anyone who requests information about the doctor's registration. The periods of time for which information should remain at the first tier should depend on the nature of the information. When the relevant period expires, the information should be removed from the website. It should be replaced by a note indicating that there is further information which can be obtained by telephoning the General Medical Council. That information should then be available at the second tier. (December 2004)	In the February 2007 Safeguarding Patients report, the Government referred to the General Medical Council as having already implemented a form of tiered disclosure.	Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**47**	Disclosure of information at the second tier should be made to any person who makes a request about a doctor's fitness to practise history. All information which has at any time been in the public domain should remain available to enquirers at the second tier for as long as the doctor remains on the register. (December 2004)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government referred to the General Medical Council as having already implemented a form of tiered disclosure.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**48**	In all cases where a GP's registration is subject to conditions, or where s/he has resumed practice after a period of suspension or erasure, patients of	The Government accepted this recommendation in principle.	Safeguarding Patients: The Government's	

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		any practice in which the GP works should be told. A letter of explanation which has been approved by the primary care trust should be sent to all patients. Patients should have the opportunity to refuse to be treated by a doctor who is subject to conditions or who has previously been subject to an order for suspension or erasure. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said it would discuss the recommendation further with NHS, professional and patient groups.	Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
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Improving patient safety	**49**	The General Medical Council should ensure that its publications contain accurate and readily understandable guidance as to the types of case that do and do not fall within the remit of its fitness to practise procedures. (December 2004)	The Government said that the General Medical Council accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government referred to the General Medical Council's publication of a new leaflet for patients which included examples of the types of cases that it investigated; the public availability of all the General Medical Council's decision-making guidance; and the re-launching of the General Medical Council's core guidance to doctors.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**50**	There must be complete separation of the General Medical Council's casework and governance functions at the investigation stage of the new	In the February 2007 Safeguarding Patients report, the Government said that the General Medical Council accepted this recommendation and that the required separation was introduced in 2004, with council members	Safeguarding Patients: The Government's Response to the recommendations	

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		fitness to practise procedures and this must be reflected in the Rules. (December 2004)	of the General Medical Council not being allowed to sit on fitness to practice panels.	of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**51**	The adjudication stage of the fitness to practise procedures must be undertaken by a body independent of the General Medical Council. This body should appoint and train lay and medically qualified panellists and take on the task of appointing case managers, legal assessors (if they are still necessary) and any necessary specialist advisers. It should also provide administrative support for hearings. (December 2004)	The Government accepted this recommendation. The Medical Practitioners Tribunal Service was established in June 2012.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**52**	Consideration should be given to appointing a body of full-time, or nearly full-time, panellists who could sit on the fitness to practise panels of all the healthcare regulatory bodies. (December 2004)	The Government accepted this recommendation. The Medical Practitioners Tribunal Service was established in June 2012. The Nurse and Midwifery Council fitness to practice panel members have a minimum requirement of 15 days per year only.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations	

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				of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. https://www.nmc.org.uk/concerns-nurses-midwives/hearings/our-panels-case-examiners/are-you-interested-in-becoming-a-panel-member	
Improving patient safety	**53**	The General Medical Council should adopt clear, objective tests to be applied by decision-makers at the investigation and adjudication stages of the Fitness to Practise procedures. The tests that recommended are set out at paragraphs 25.63 and 25.67–25.68. The tests should be incorporated into the Medical Act 1983 and/or the Rules. The draft Guidance for Fitness to Practise panellists should be amended so that it is consistent with the provisions of Section 35D of the Medical Act 1983 and rule 17(2)(k) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 (the November 2004 Rules). (December 2004)	The Government referred to amendment by the General Medical Council of its draft guidance to panellists to ensure consistency with the provisions of Section 35D of the Medical Act 1983 and rule 17(2)(k) of the General Medical Council (Fitness to Practise) Rules Order 2004. In the February 2007 Safeguarding Patients report, the Department of Health said it intended to commission a review of the General Medical Council's processes 4 years after the introduction of the reformed procedures.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving patient safety	**54**	The Medical Act 1983 should be amended to add a further route by which there might be a finding of impairment of fitness to practise, namely 'deficient clinical practice'. (December 2004)	The Government rejected this recommendation.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**55**	Urgent steps should be taken to develop standards, criteria and thresholds so that decision-makers will be able to reach reasonably consistent decisions at both the investigation and the adjudication stages of the fitness to practise procedures and on restoration applications. (December 2004)	In the February 2007 Safeguarding Patients report, the Government referred to the development by the General Medical Council of guidance for its decision-makers at the investigation and adjudication stages of the fitness to practise procedures, which included examples of the types of cases where failure to meet standard may put registration at risk.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**56**	The Council for the Regulation of Healthcare Professionals (now known as the Council for Healthcare Regulatory Excellence should be invited to set up a panel of professional and lay people	In the February 2007 Safeguarding Patients report, the Government said it agreed that the Council for Healthcare Regulatory Excellence could play a valuable role in	Safeguarding Patients: The Government's Response to the	

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		(similar in nature to the Sentencing Advisory Panel) which should assist in the process of developing the necessary standards, criteria and thresholds. (December 2004)	promoting greater consistency in standards between the professional regulators.	recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**57**	Steps should be taken to ensure that fitness to practise panels determining cases in which issues of deficient professional performance arise apply a standard which is no lower than that set for admission to general practice. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said it agreed with the General Medical Council's view that individuals ought to be assessed on the basis of their particular experience and expertise. It referred to the General Medical Council working on assessment tools in each specialty to reflect that approach. It made no mention of the standard which would apply,	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**58**	Rule 4 of the General Medical Council (Fitness to Practise) Rules Order of Council 2004, which sets out the test to be applied by the Registrar on receipt of an allegation, should be amended to give greater clarity. 5. (December 2004)	In the February 2007 Safeguarding Patients report, the Government referred to the General Medical Council having clarified the test to be applied by the Registrar and redrafted the guidance on the fitness to practice rules to reflect this clarification. No amendment was made to Rule 4 until 2009.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report	

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				and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2009	
Improving patient safety	**59**	The General Medical Council (Fitness to Practise) Rules Order of Council 2004 should be amended to make formal provision for the General Medical Council routinely to communicate with employers and with primary care organisations before deciding what action should be taken in response to an allegation and giving the General Medical Council power to require from the doctor the necessary details to enable it to make such communication. Communication should take place in all cases other than in the case of an allegation which is so serious that it obviously requires further investigation or in the case of an allegation which is plainly outside the General Medical Council's remit. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said it agreed that the General Medical Council should routinely involve employers and primary care trusts in deciding how cases should be handled and said that this was now standard practice following changes in 2004 to the fitness to practise procedures. Not implemented via amendment of the General Medical Council (Fitness to Practise) Rules Order of Council 2004.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving patient safety	**60**	Where a doctor has committed a criminal offence in respect of which a court has imposed a conditional discharge, that offence should be dealt with by the General Medical Council in the same way as if it were a criminal conviction. (December 2004)	In the February 2007 Safeguarding Patients report, the Government referred to the Registrar's discretion to refer to a fitness to practise panel all convictions and cautions which do not result in custodial sentences. The Department of Health said it intended to commission a review of the General Medical Council's processes 4 years after the introduction of the reformed procedures and to consider treatment of conditional discharges at that point.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**61**	The General Medical Council (Fitness to Practise) Rules Order of Council 2004 should be amended so as to give case examiners, and Investigation Committee panels in cases where the case examiners have disagreed, the power to direct investigations. (December 2004)	In the February 2007 Safeguarding Patients report, the Government referred to the ability of case examiners and the Investigation Committee to seek any information or evidence they need before making a decision, as well as the guidance to the fitness to practise rules having been redrafted to reflect this.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**62**	Case examiners should be advised that they should not take mitigation into account when making their decisions and that they should consult a lawyer if they are in any doubt as to whether the available	In the February 2007 Safeguarding Patients report, the Government said that case examiners were advised to consult a lawyer where there were any concerns about the available evidence. The Government referred to the	Safeguarding Patients: The Government's Response to the	

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		evidence is such that there is a realistic prospect of proving the allegation. (December 2004)	General Medical Council having in-house lawyers to support investigations and provide advice to decision-makers at the investigation stage of fitness to practise proceedings. The Government also said that the General Medical Council had advised case examiners not to take mitigation into account when making decisions.	recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**63**	The General Medical Council (Fitness to Practise) Rules Order of Council 2004 should be amended to give case examiners, and Investigation Committee panels in cases where the case examiners have disagreed, the power to direct that an assessment of a doctor's performance and/or health should be carried out. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that case examiners and the Investigation Committee could seek any information or evidence they needed before making a decision on a case, which would include assessment of a doctor's performance or health. The guidance to the fitness to practise rules had been redrafted to reflect this, with the General Medical Council intending to consult on the revised guidance. Rule 13A was inserted by the General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2009, which gave the Registrar the power to direct that an assessment of the practitioner's performance or health be carried out. The same power was not given to case examiners.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2009	

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Improving patient safety	**64**	The General Medical Council should develop an abridged performance assessment to be used as a screening tool in any case in which an allegation is made which potentially calls into question the quality of a doctor's clinical practice. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that the General Medical Council had undertaken work with the Royal Colleges on the development of assessment instruments for modular assessment. By the General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2009, the Registrar was given the power to direct an assessment of the practitioner's performance following referral.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2009	
Improving patient safety	**65**	In order to avoid doctors undergoing multiple performance assessments, the General Medical Council should investigate the development of a modular assessment. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that the General Medical Council had undertaken work with the Royal Colleges on the development of assessment instruments for modular assessment. It is unclear what the result of this work was.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations	

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				of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**66**	The General Medical Council (Fitness to Practise) Rules Order of Council 2004 should be amended to include a provision whereby reports of performance assessments should be disclosed by the General Medical Council to doctors' employers or primary care organisations as soon as possible after receipt. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that the duty to share the performance assessment report with an employer was in the rules at Rule 7(5) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004. The Government did not address the recommendation of disclosure to primary care organisations.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**67**	The power to send letters of advice should be incorporated into the Rules and clear criteria for the sending of such letters should be prepared. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that the power to send letters of advice was incorporated in the revised guidance to the fitness to practise rules, and which included reference to the types of case in which a letter of advice might be the appropriate response. No amendment to the rules themselves was made.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

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				Inquiries, February 2007.	
Improving patient safety	**68**	The General Medical Council should reconsider its proposals for the issuing of warnings at the investigation stage. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that the General Medical Council had been closely monitoring the issuing of warnings at the investigation stage and was satisfied that they were working effectively.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**69**	Rule 28 of the General Medical Council (Fitness to Practise) Rules Order of Council 2004, which provides for the cancellation of hearings before a fitness to practise panel, should be amended so as to provide that a decision to cancel must be taken by an Investigation Committee panel and that the reasons for the cancellation must be formally recorded. Both the doctor and the maker of the allegation should be notified in advance of the fact that cancellation is being considered and both should have the opportunity to make representations. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that the General Medical Council had redrafted the guidance to the fitness to practise rules, which were to provide that representations would be sought from the practitioner and the makers of the allegation, with separate guidance for decision-making on dealing with applications for cancellations. The Government also said that the Department of Health intended to commission a review of the General Medical Council's processes 4 years after the introduction of the reformed procedures. Rule 28 was amended by the General Medical Council (Miscellaneous Amendments) Order of Council 2017.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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			However, no requirement that the decision to cancel/withdraw must be taken by an Investigation Committee panel was imposed.	The General Medical Council (Miscellaneous Amendments) Order of Council 2017.	
Improving patient safety	**70**	There should be regular monitoring and audit of the number of applications to cancel fitness to practise panel hearings and of decisions to cancel and the reasons for those applications and decisions. Those reasons should be scrutinised with a view to taking steps to minimise the number of cases in which referrals are subsequently cancelled. The number and reasons should be placed in the public domain on an annual basis. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that the General Medical Council undertook quality assurance of decisions to cancel referrals and would review the information published on its fitness to practise procedures. The Government also referred to the introduction of a new IT system by the General Medical Council, which would enable it to publish fuller and more detailed statistical information.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**71**	If the General Medical Council pursues its present intention to extend the use of voluntary undertakings to cases other than those raising issues of adverse health or deficient performance, the disposal of such cases should take place in public at the adjudication stage and not in private as part of the investigation stage. (December 2004)	Provision for consensual disposal was included in the Medical Act and Miscellaneous Amendments Order 2006. It was said the General Medical Council would consult on amended rules in 2007. The General Medical Council (Fitness to Practise) Rules Order of Council 2004 enables case examiners to make use of voluntary undertakings in cases where the practitioner's fitness to practise is impaired.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

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			In the February 2007 Safeguarding Patients report, the Government said that undertakings restricting a doctor's practice would be published on the General Medical Council Register and monitored in the same way as conditions imposed by a panel, with medical supervisors appointed to support the remediation and re-training purpose.	Inquiries, February 2007.	
Improving patient safety	**72**	The General Medical Council (Fitness to Practise) Rules Order of Council 2004 should be amended to make provision for the revival of closed allegations. The usual 'cut-off' period should be five years but it should be possible, in exceptional circumstances and in the interests of patient protection, to reopen a case at any time. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said it agreed that closed allegations could in certain circumstances have continuing relevancy to the protection of patients. However, the Government said that legal and ethical issues arose and that the General Medical Council had received legal advice that unfettered discretion to re-open a case at any time could be open to legal challenge. The Department of Health said it would discuss options with the General Medical Council,	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**73**	Reviews of investigation stage decisions should be carried out by an independent external commissioner. The circumstances in which a review may take place should be extended to cover decisions of the Registrar to reject an allegation rather than to refer it to a case examiner. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that it agreed a sample of decisions at the investigation stage ought to be subject to independent audit by the Council for Healthcare Regulatory Excellence. In turn, the Council for Healthcare Regulatory Excellence would report annually to Parliament on whether patient safety interests had been properly considered in the	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the	

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			decisions and operations of the regulators on fitness to practise cases. .	recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century, February 2007.	
Improving patient safety	**74**	The General Medical Council (Fitness to Practise) Rules Order of Council 2004 should be amended so as to provide that the arrangements for the obtaining and consideration of health assessments and for the management and supervision of doctors who are the subject of voluntary undertakings relating to health should be directed by a medically qualified case examiner, who should fulfil the functions previously carried out by a health screener. If a case is to be closed on the basis of a health assessment, the decision should be taken by two case examiners, one medically qualified and one lay, and, if they disagree, by an Investigation Committee panel. (December 2004)	In the February 2007 Safeguarding Patients report, the Government agreed with this recommendation and said that this reflected then practice and policy and was covered by the General Medical Council guidance.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving patient safety	**75**	The General Medical Council (Fitness to Practise) Rules Order of Council 2004 should be amended so as to provide that the arrangements for the obtaining and consideration of performance assessments and for the management and supervision of doctors who are the subject of voluntary undertakings relating to performance should be directed by a medically qualified case examiner, who should fulfil the functions previously carried out by a performance case co-ordinator. If a case is to be closed on the basis of a performance assessment, the decision should be taken by two case examiners, one medically qualified and one lay, and, if they disagree, by an Investigation Committee panel. (December 2004)	In the February 2007 Safeguarding Patients report, the Government agreed with this recommendation and said that this reflected then practice and policy and was covered by the General Medical Council guidance.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**76**	There should be an explicit power in the Rules to allow the General Medical Council to undertake any further investigations it considers necessary after a case has been referred to a fitness to practise panel and before the panel hearing. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said this reflected existing practice and policy and was covered in General Medical Council guidance.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving patient safety	**77**	In the event that the General Medical Council retains control of the adjudication stage, the General Medical Council committee charged with governance of the adjudication stage should audit the work of case managers. Case management should apply to cases with a performance element. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that this recommendation would be brought to the attention of the independent adjudicator in due course, and in the meanwhile the General Medical Council would ensure that case management applied in all cases and had in place a process to review and quality assure decisions taken by case managers.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**78**	Fitness to practise panellists should be warned that they should exercise caution about drawing adverse inferences from a failure to comply with case management orders. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that it would draw this recommendation to the attention of the independent adjudicator in due course, and meanwhile the General Medical Council had revised its guidance to reflect this recommendation. .	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**79**	In the event that the General Medical Council retains control of the adjudication stage, it should appoint a number of legally qualified chairmen who should, as an experiment or pilot, preside over the	In the February 2007 Safeguarding Patients report, the Government said it would draw this recommendation to the attention of the independent adjudicator.	Safeguarding Patients: The Government's Response to the	

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		more complex fitness to practise panel hearings. The results of the pilot scheme should be scrutinised to see whether there are benefits, whether in terms of the improved conduct of hearings, more consistent outcomes, improved reasons and/or fewer appeals. (December 2004)		recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**80**	As part of their training, fitness to practise panellists should be advised about their discretion to admit hearsay evidence and other forms of evidence not admissible in a criminal trial. Panellists should also be advised, during training, that it is entirely appropriate for them to intervene during fitness to practise panel hearings and to ask questions if they feel that any issue is not being adequately explored. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that these matters had been included in the General Medical Council guidance and training for panellists.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**81**	The General Medical Council should reopen its debate about the standard of proof to be applied by fitness to practise panels. The civil standard of proof is appropriate in a protective jurisdiction. It is arguable that the criminal standard of proof is appropriate in a case where the allegations of	In the February 2007 Safeguarding Patients report, the Government said it had decided that all health professions regulators should follow the civil standard of proof, which should be flexibly applied to take into account the circumstances and gravity of individual cases.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the	

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		misconduct amount to a serious criminal offence. (December 2004)		recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**82**	The General Medical Council should abandon its intention to notify doctors, at the same time as sending notice of referral of their case to a fitness to practise panel, of the outcome it will be seeking at the fitness to practise panel hearing. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that the General Medical Council had guidance and no longer adopted this approach.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**83**	Fitness to practise panels should be required to give brief reasons for their main findings of fact. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said it would draw this recommendation to the attention of the independent adjudicator.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

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				Inquiries, February 2007.	
Improving patient safety	**84**	Rule 17(5)(b) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 (which permits a fitness to practise panel, on receipt of a report of a health or performance assessment, to refer the allegation back into the investigation stage for consideration of voluntary undertakings) should be revoked. (December 2004)	The Government rejected this recommendation. In the February 2007 Safeguarding Patients report, the Government said that, although only the most potentially serious cases would need to go to the independent adjudicator, it believed that remedial action based on voluntary undertaking should remain an option at that stage.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**85**	Rule 17(2)(j) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 should be amended to make clear what types of further evidence should be received before a fitness to practise panel decides whether a doctor's fitness to practise is impaired. That evidence should include the doctor's previous fitness to practise history with the General Medical Council or any other regulatory body. Rule 17(2)(l) should be amended to make clear what categories of evidence might be received after a finding of impairment of fitness to practise but before determination of sanction. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that this recommendation reflected existing General Medical Council policy and practice, and that the General Medical Council had redrafted its guidance to the fitness to practise rules to reflect this. The Government also said that the recommendation would be brought to the attention of the independent adjudicator in due course. However, Rule 17(2)(k) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004, which makes provision for receiving further evidence, does not specify what types of further evidence should be received.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving patient safety	**86**	The Medical Act 1983 should be amended to permit a fitness to practise panel to issue a warning in a case where it has found that a doctor's fitness to practise is impaired but not to a degree justifying action on registration. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that it would, in due course, seek the view of the independent adjudicator and other stakeholders on this recommendation. Section 35D(3) of the Medical Act 1983 still only permits a Medical Practitioners Tribunal to give a warning where it finds a person's fitness to practise is not impaired.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Section 35D(3) Medical Act 1983	
Improving patient safety	**87**	Rule 17(2)(m) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004, which permits a fitness to practise panel to take into account written undertakings entered into by a doctor when deciding how to deal with the doctor's case, should be revoked. If it is to be retained, the rule should be amended to make clear that undertakings can be taken into account only at the stage of deciding on sanction, after findings of fact and a decision about impairment of fitness to practise have been made. In that event also, provision should be made within the Rules for supervision of the doctor to ensure compliance with undertakings, for the holding of review hearings in	In the February 2007 Safeguarding Patients report, the Government said that this recommendation reflected existing General Medical Council policy and practice, and that the General Medical Council had redrafted its guidance to the fitness to practise rules to reflect this. The Government also said that the recommendation would be brought to the attention of the independent adjudicator in due course. Rules 17(3) and 17(4) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 permit the Medical Practitioners Tribunal to take into account undertakings when deciding how to dispose of a case	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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		cases where a doctor has given undertakings and for dealing with a breach of an undertaking. (December 2004)	where a practitioner's fitness to practise is found to be impaired.	The General Medical Council (Fitness to Practise) Rules Order of Council 2004	
Improving patient safety	**88**	Throughout the period that a doctor's registration is subject to conditions imposed by a fitness to practise panel or to voluntary undertakings, someone within the General Medical Council (preferably a case examiner) should take responsibility for monitoring the doctor's progress and for ensuring, so far as possible, that s/he is complying with the conditions imposed or undertakings given. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said it agreed with this recommendation and that it reflected currently policy and practice. The Government stated that the General Medical Council established a case review team in 2004 to undertake this work. The Government referred to medical supervisors and workplace supervisors and members of the case review team liaising to ensure that the practitioner was complying with any conditions or undertaking, with medically qualified case examiners being involved in the review process. The Government said that these arrangements would be reviewed once the independent adjudicator had been set up.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**89**	In every case where a doctor is continuing to practise subject to conditions or voluntary undertakings, a professional supervisor should be appointed to oversee and report on the doctor's progress and on his/her compliance with the conditions or undertakings. In a case where a doctor's health is an issue, a medical supervisor should be appointed. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said it agreed with this recommendation and that it reflected currently policy and practice. The Government stated that the General Medical Council established a case review team in 2004 to undertake this work. The Government referred to medical supervisors and workplace supervisors and members of the case review team liaising to ensure that the practitioner was complying	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations	

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			with any conditions or undertaking, with medically qualified case examiners being involved in the review process. The Government said that these arrangements would be reviewed once the independent adjudicator had been set up.	of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**90**	Any breach of a condition imposed by a fitness to practise panel or of a voluntary undertaking (save for the most minor breach) should result in the doctor being referred back (or referred) to a fitness to practise panel so that consideration can be given to imposing a sanction which affords a greater degree of protection to the public. (December 2004)	The Government agreed to this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said the recommendation reflected current General Medical Council policy as set out in the revised guidance to the Fitness to Practise rules. The Government stated further discussion was needed on how to put this principle in effect once the independent adjudicator was set up. Rules 10(8) and 37A(5)) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 permit referral to the Medical Practitioners Tribunal in the event of failure to observe an undertaking.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The General Medical Council (Fitness to Practise) Rules Order of Council 2004	
Improving patient safety	**91**	The General Medical Council (Fitness to Practise) Rules Order of Council 2004 should be amended to ensure that there is at least one review hearing in all cases where a period of suspension or	In the February 2007 Safeguarding Patients report, the Government said that this reflected General Medical Council policy and practice and that the guidance to the fitness to practise rules.	Safeguarding Patients: The Government's Response to the	

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		conditions on registration have been imposed, unless there are exceptional reasons why no such hearing should take place. (December 2004)	The Government said that the recommendation would be brought to the attention of the independent adjudicator in due course.	recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**92**	The arrangements set out in the draft General Medical Council (Fitness to Practise) Rules 2003 (the 2003 draft Rules), whereby any necessary gathering of evidence in preparation for a review hearing would be undertaken by a specially appointed case examiner, should be reinstated. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said General Medical Council policy was for case examiners to be involved in preparing cases for review where the conditions related to a doctor's performance or health.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**93**	In all but exceptional cases, a doctor whose registration has been suspended should be required to undergo an objective assessment of his/her fitness to practise before being permitted to return to practice. That assessment should be considered by a fitness to practise panel at a review	In the February 2007 Safeguarding Patients report, the Government agreed in principle with this recommendation. The Government said that in certain circumstances the evidence gathered for revalidation may be sufficient to establish objective evidence of fitness to practise. The Government referred to existing General Medical Council	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report	

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		hearing and a decision should be taken as to the doctor's fitness to practise. A doctor who has been the subject of conditions on his/her registration should be required to go through the same process. Doctors who are the subject of voluntary undertakings should also be required to undergo such an assessment before their undertakings are permitted to lapse. (December 2004)	Rules as giving the Registrar the power to require a doctor to undergo an assessment, with such power being discretionary. The Government suggested the General Medical Council ought to discuss the recommendation further with the independent adjudicator when established.	and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**94**	The General Medical Council's primary role should be one, not of remediation of doctors, but of protection of patients. If a doctor who is subject to conditions or voluntary undertakings undergoes an assessment in the circumstances described above, and the assessment reveals that s/he does not meet the required standard, consideration should be given to taking the steps necessary to remove the doctor from practice. He or she should not be permitted to 'limp on' with repeated periods of conditional registration and no real hope of meeting the standard for unrestricted practice. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that it agreed that the primary role of regulation should be to protect patients. The Government said that erasure was not then available for doctors whose fitness to practise was impaired solely by reason of ill-health, but indefinite suspension was available. The Government stated that further discussion would be needed once the independent adjudicator was established.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**95**	The arrangements set out in the 2003 draft Rules, whereby any necessary gathering of evidence in preparation for a restoration hearing should be undertaken by a specially appointed case examiner, should be reinstated. (December 2004)	In the February 2007 Safeguarding Patients report, the Government referred to General Medical Council policy, which was that, on receipt of an application for restoration, for the Registrar to make any investigation considered appropriate, including requiring the applicant to undergo a performance or health assessment. Case examiners would	Safeguarding Patients: The Government's Response to the recommendations of the Shipman	

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			be involved where a performance or health assessment was undertaken. The Government suggested the General Medical Council discuss the recommendation with the independent adjudicator once established. The current General Medical Council (Fitness to Practise) Rules Order of Council 2004 do not require a specially appointed case examiner to gather the evidence in preparation for a restoration hearing.	Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The General Medical Council (Fitness to Practise) Rules Order of Council 2004	
Improving patient safety	**96**	Every doctor whose application for restoration to the register has reached the second stage of the procedure should be required to undergo an objective assessment of every aspect of his/her fitness to practise. The doctor should not be restored to the register unless s/he has met the required standard. (December 2004)	The Government agreed in principle with this recommendation. In the February 2007 Safeguarding Patients report, the Government said that existing rules gave the Registrar the power to require the applicant to undergo an assessment but that power was discretionary. The Government stated that it, in practice, fitness to practise panels often required an assessment at this stage of the process. The current General Medical Council (Fitness to Practise) Rules Order of Council 2004 maintain the discretionary, and not mandatory, nature of the power.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The General Medical Council	

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				(Fitness to Practise) Rules Order of Council 2004	
Improving patient safety	**97**	Doctors who are restored to the register should be required to have a mentor whose task it will be to monitor, and report to the General Medical Council on, their progress in practice. (December 2004)	The Government agreed to this recommendation. In the February 2007 Safeguarding Patients report, the Government said it would require the National Clinical Assessment Service and the General Medical Council to work together with employers to agree specific packages of rehabilitation and conditions on practice, following a comprehensive assessment, where fitness to practice has been called into question.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**98**	A thorough investigation of the circumstances underlying allegations of misconduct involving drug abuse should be conducted. The full facts should be established, including the circumstances in which the abuse began. (December 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said that the General Medical Council's reformed fitness to practise procedures would allow for this as it could investigate both the conduct issues and any underlying health problems and review the doctor's fitness to practise in the round. The Government also stated that a national advisory group, advising on national strategy to ensure the health of health professionals, would be asked to consider the need for access to addiction services.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving patient safety	**99**	The General Medical Council should commission research into drug abusing doctors and the outcomes of their cases following supervision under the health procedures. (December 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said it would discuss the recommendation further with the General Medical Council, who had entered into a strategic partnership with the Economic and Social Research Council to fund a programme on medical regulation.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**100**	Every aspect of the fitness to practise procedures in which either doctors or makers of allegations have a direct interest should be set out in the Rules. In addition, the General Medical Council should publish a fitness to practise manual, containing all its relevant Rules and its guidance for panellists, case examiners and staff, together with any relevant Standing Orders. (December 2004).	The Government rejected the recommendation that every aspect of the fitness to practice procedure in which doctors or makers of allegations have direct interest be set out in the Rules. In the February 2007 Safeguarding Patients report, the Department of Health stated that its policy was that operational detail should be set out in published guidance. The Government agreed that the General Medical Council ought to publish a fitness to practise manual. It referred to the publication of the General Medical Council's rules and decision-making guidance on its website. The Government also said it would draw attention to this recommendation to the independent adjudicator to ensure that guidance on all stages of the fitness to practise processes would continue to be publicly available.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving patient safety	**101**	Clear statistical information should be collected and published by the General Medical Council. The General Medical Council should publish an annual report which should amount to a transparent statement of the year's activities in respect of the fitness to practise procedures. (December 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government referred to the recent introduction of a new IT system at the General Medical Council, to allow them to gather and publish more detailed information about fitness to practise procedures. The General Medical Council currently publishes annual fitness to practise statistics.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**102**	The General Medical Council should carry out audits of various specific aspects of its procedures, in addition to its other routine auditing activities. (December 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said that all aspects of the General Medical Council's procedures as well as decisions at the investigation stage and adjudication stage of the process are subject to regular review and quality assurance. The Government also referred to a full audit programme of General Medical Council procedures taking place under the auspices of the Audit Committee. The Government also said it would invite the Council for Healthcare Regulatory Excellence to audit a sample of decisions from the General Medical Council's fitness to practise processes.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**103**	The arrangements for revalidation should be amended so that revalidation comprises, as required by section 29A of the Medical Act 1983, an	The Government said it agreed with this recommendation.	Safeguarding Patients: The Government's Response to the	

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		evaluation of an individual doctor's fitness to practise. (December 2004)		recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**104**	The annual report referred to at 101 above should include clear statistical information about the number of applications for revalidation and their outcomes. It should amount to a transparent statement of the year's revalidation activities. (December 2004)	In the February 2007 Safeguarding Patients report, the Government said that the General Medical Council agreed in principle with this recommendation and would review its plan in light of its approach to revalidation.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**105**	In three to four years' time, there should be a thorough review of the operation of the new fitness to practise procedures, to be carried out by an independent organisation. This task should be undertaken by or on the instructions of the Council for Healthcare Regulatory Excellence. (December 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Department of Health proposed to commission a review of the General Medical Council's new fitness to practise processes 4 years after their introduction and proposed this would be a suitable task for the Council for Healthcare Regulatory Excellence.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the	

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				recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving NHS culture and governance	**106**	The General Medical Council's constitution should be reconsidered, with a view to changing its balance, so that elected medical members do not have an overall majority. Medical and lay members who are to be appointed (by the Privy Council) should be selected for nomination to the Privy Council by the Public Appointments Commission following open competition. (December 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government decided that all members of all councils would be appointed by independently by the Appointments Commission against clearly specified criteria and competencies. This recommendation was implemented by the General Medical Council (Constitution) Order 2008.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The General Medical Council (Constitution) Order 2008	
Improving NHS culture and governance	**107**	The General Medical Council should be directly accountable to Parliament and should publish an annual report which should be scrutinised by a Parliamentary Select Committee. (December 2004)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said it would put in place measures to ensure accountability on the part of the professional regulatory councils direct to the UK Parliament.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report	

The Shipman Inquiry: Fifth Report					
				and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving NHS culture and governance	**108**	Section 29 of the National Health Service Reform and Health Care Professions Act 2002 should be amended so as to clarify that the Act provides for the Council for Healthcare Regulatory Excellence to appeal against 'acquittals' and findings of 'no impairment of fitness to practise', as well as in respect of sanctions which it believes were unduly lenient. (December 2004)	In the February 2007 Safeguarding Patients report, the Government referred to the Court of Appeal's decision in *Council for the Regulation of Health Care Professionals v General Medical Council* [2004] EWCA Civ 1356 as having already established this principle.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving NHS culture and governance	**109**	There should in the future be a review of the powers of the Council for Healthcare Regulatory Excellence with a view to ascertaining whether any extension of its powers and functions is necessary in order to enable it to act effectively to ensure that patients are sufficiently protected by the General Medical Council. (December 2004)	In the February 2007 Safeguarding Patients report, the Government suggested that the Council for Healthcare Regulatory Excellence should instead increasingly focus its efforts on harmonisation of the standards and processes of the regulators rather than scrutiny and challenge of individual decisions.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

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				Inquiries, February 2007.	

10 NORTHWICK PARK HOSPITAL, NORTH WEST LONDON HOSPITALS NHS TRUST (HEALTHCARE COMMISSION INVESTIGATION)

10.1 Introduction

This investigation into maternity services was conducted by the Healthcare Commission, derived from its statutory powers, into the North West London Hospitals NHS Trust, with a focus on the Maternity Unit at Northwick Park Hospital.

Timeline of Investigation

In October 2004, the Trust invited the Healthcare Commission to look at the maternity unit at Northwick Park Hospital following the nine maternal deaths between April 2002 and June 2004. The Healthcare Commission initially examined the trust's internal review in October 2004 and concurred with its findings.

In December 2004, the Healthcare Commission review team visited the Trust in December 2004 and asked for urgent action on a few points. The Trust subsequently undertook to put urgent remedial actions in place and the Healthcare Commission undertook to monitor progress.

A further maternal death then took place in March 2005. It was on 1 April 2005 that the Strategic Health Authority informed the Commission of this death. As a result, the investigators from the Healthcare Commission carried out an unannounced inspection on 11 April 2005, examined case notes and examined staff statements.

At the recommendation by the Healthcare Commission, the Department of Health introduced special measures at the maternity unit on 21st April 2005.

On 7 July 2005 the Healthcare Commission published its report of the investigation into maternity services at North West London NHS Trust. The report covers events in the trust's maternity services prior to the introduction of special measures. The report can be viewed online.

On 23 August 2006 the Healthcare Commission published its second report into maternity services at North West London NHS Trust, with more in-depth findings on the maternal deaths and included more general recommendations towards the wider NHS. This report can also be viewed online. The Secretary of State for Health lifts special measures from Maternity Unit at Northwick Park Hospital on 22 September 2006.

10.2 Inquiry into Northwick Park, North West London Hospitals NHS Trust: Table of Recommendations

Inquiry into Northwick Park, North West London Hospitals NHS Trust					
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
Urgent and immediate action (Interim recommendations) – December 2004					
Improving patient safety	**UA1**	The Healthcare Commission's review team visited the trust in December [2004] and asked for urgent action to be taken on the following: • to ensure that there is 40 hours of cover by consultants on the labour ward each week; • to ensure that funding is available for the use of temporary staff to meet safe levels of staffing; • to immediately recruit staff specifically trained in the postoperative care of women and ensure that temporary arrangements are in place until new staff commence employment; • to identify ways temporarily to reduce demand on the service; • to review operational procedures for the management of women who are overseas visitors or asylum seekers; • to improve access to interpreters, particularly when women require care at short notice or in an emergency • to provide additional formal support for the team managing the maternity services • to review fire safety arrangements, particularly fire exits	*"The Healthcare Commission received a letter from the chief executive of the trust, dated December 16th 2004, stating that the urgent and immediate actions were either complete or were in the process of being completed".* (p. 47) April 2005: Participants indicated on that day the trust had not taken forward some of the urgent and immediate actions identified as being necessary in December 2004. Of particular concern was the trust's failure to reduce the workload of staff in maternity services. (p. 48) North West London Hospitals NHS Trust developed Action plan to address the recommendations. (May 2005)	Healthcare Commission, 'Review of maternity services provided by North West London Hospitals NHS Trust' (July 2005) North West London Hospitals NHS Trust, 'Action plan arising from a responsive review of Maternity Services by the Healthcare Commission and from Special Measures' (May 2005)	

Inquiry into Northwick Park, North West London Hospitals NHS Trust					
		• to ensure regular reports on progress are provided to the trust's board.			
Special Measures – April 2005					
Improving NHS culture and governance	**SM1**	In response to concerns about the ability of the trust to respond effectively to the high volume of women who were currently using the maternity services, we recommended that: • urgent steps be taken to increase capacity in the maternity services – in particular, that arrangements be made for elective caesarean deliveries to be undertaken elsewhere without delay • external clinical support be provided to the trust, with the help of the National Clinical Governance Support Team – this should include external clinical staff to provide daily supervision on the wards, external mentoring for the medical director designate and for the clinical director for maternity services – also, direct support should be provided from the National Clinical Governance Support Team to improve the way in which staff work together • support be provided to the trust to ensure that they can implement appropriate performance measures where necessary to address the serious difficulties that existed with working relationships between different clinical staff (In April 2005 the Department of Health, at the request of the Healthcare Commission, introduced	*"The Secretary of State for Health responded immediately to all of these recommendations and agreed to provide a package of support so that action could be urgently implemented. The Healthcare Commission is meeting regularly with the trust, strategic health authority and the PCTs to monitor progress in the implementation of special measures and the urgent and immediate actions we identified." (p. 49)* Special Measures lifted from the Maternity Unit at Northwick Park Hospital (September 2006).	Healthcare Commission, 'Review of maternity services provided by North West London Hospitals NHS Trust' (July 2005) North West London Hospitals, 'Special measures lifted from maternity unit following positive changes' (22 September 2006)	

Inquiry into Northwick Park, North West London Hospitals NHS Trust					
		special measures at the maternity unit to accelerate the improvement activities being undertaken by the Trust. This was after the Healthcare Commission was informed that another maternal death occurred in March 2005, and carried out an unannounced visit in April 2005)			
Additional Recommendations – July 2005 Report					
Management, leadership and working in partnership with others					
	1	The trust should work with its partners in the local health community temporarily to commission additional capacity from neighbouring healthcare providers while the recommendations of this review are acted on. (July 2005)	The Trust adopted into May 2005 action plan under Action 16.1. Unable to locate evidence of full completion.	North West London Hospitals NHS Trust, 'Action plan arising from a responsive review of Maternity Services by the Healthcare Commission [etc]' (May 2005)	
	2	The trust's board should be assured of the quality of project management for major capital projects such as the refurbishment of maternity services. (July 2005)	Healthcare Commission reports: improvements include the refurbishment of the labour ward which now includes a high dependency unit. (p. 107) (August 2006)	Healthcare Commission, 'Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS	

Inquiry into Northwick Park, North West London Hospitals NHS Trust					
				Trust, between April 2002 and April 2005' (August 2006)	
Regulation and oversight of NHS managers	**3**	Support from within the trust for the current leadership team in maternity services should be provided as well as external mentoring. (July 2005)	Healthcare Commission reports: *"The number of supervisors of midwives has been increased and is in line with national guidance."* (p. 107) (August 2006)	Healthcare Commission, 'Investigation into 10 maternal deaths [etc.]' (August 2006)	
Improving the ability to raise complaints and concerns	**4**	The trust should ensure that there are effective systems of communication with primary care trusts and the strategic health authority on the quality of maternity services being provided. This must include the routine reporting of serious untoward incidents. (July 2005)	The Trust adopted the recommendation into its May 2005 action plan under Actions 19.1 and 19.2. Unable to locate evidence of full completion.	North West London Hospitals NHS Trust, 'Action plan arising from a responsive review of Maternity Services by the Healthcare Commission [etc]' (May 2005)	
	5	The strategic health authority, primary care trusts and the trust should work together to engage with the local community and ensure that maternity services reflect the diverse needs of the population. (July 2005)	The Trust adopted the recommendation into its May 2005 action plan under Actions 20.1, 20.2, 20.3, 20.4, 20.5. Unable to locate evidence of full completion.	North West London Hospitals NHS Trust, 'Action plan arising from a responsive review of Maternity Services by the	

Inquiry into Northwick Park, North West London Hospitals NHS Trust					
				Healthcare Commission [etc]' (May 2005)	
The management of risk and other systems of clinical governance					
Improving NHS culture and governance	**6**	The trust's board must be assured that effective systems and processes of integrated governance are in place across the trust to share learning both from individual incidents and from emerging themes of incidents. (July 2005)	Healthcare Commission reports: *"The policy for reporting and managing serious untoward incidents has been revised. The Commission was told that the trust is focusing on learning from incidents and staff confirmed that there is less of a "blame culture"."* (p. 107) (August 2006)	Healthcare Commission, 'Investigation into 10 maternal deaths [etc.]' (August 2006)	
Improving NHS culture and governance	**7**	The purpose and frequency of all meetings held in the maternity services should be reviewed to maximise attendance at clinical meetings and to ensure an effective labour ward forum is established. (July 2005)	The Trust adopted the recommendation into its May 2005 action plan under Action 10.1. Unable to locate evidence of full completion.	North West London Hospitals NHS Trust, 'Action plan arising from a responsive review of Maternity Services by the Healthcare Commission [etc]' (May 2005)	
	8	The new clinical maternity information system, approved by the board in August 2004, for collecting, coding and analysing information about the quality of care provided in maternity services must be introduced without delay and the training of	The Trust adopted the recommendation into its May 2005 action plan under Actions 11.1, 11.2, 11.3, and 11.4. Unable to locate evidence of full completion.	North West London Hospitals NHS Trust, 'Action plan arising from a responsive review	

Inquiry into Northwick Park, North West London Hospitals NHS Trust					
		staff should be planned to support its introduction. (July 2005)		of Maternity Services by the Healthcare Commission [etc]' (May 2005)	
	9	Record keeping, especially records about the plan of care for birth, must be audited and relevant action taken on all the findings of the audit. (July 2005)	The Trust adopted the recommendation into its May 2005 action plan under Actions 12.1, 12.2, 12.3, 12.4 and 12.5. Unable to locate evidence of full completion.	North West London Hospitals NHS Trust, 'Action plan arising from a responsive review of Maternity Services by the Healthcare Commission [etc]' (May 2005)	
Improving patient safety	**10**	Up-to-date clinical guidelines should be widely available throughout maternity services, and be regularly reviewed. Awareness of and compliance with guidelines by the staff must be improved and monitored. (July 2005)	Healthcare Commission reports: Up-to-date clinical guidelines have been developed and implemented. Paper copies of the guidelines are kept in each of the rooms on the delivery suite and are also available on the trust's intranet. Individual copies have been distributed to clinical staff. *(p. 107)* The number of supervisors of midwives has been increased and is in line with national guidance. *(p. 107)* (August 2006)	Healthcare Commission, 'Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April	

Inquiry into Northwick Park, North West London Hospitals NHS Trust					
				2005' (August 2006)	
Improving patient safety	**11**	Staff caring for women after surgery in maternity services, or for women who require invasive monitoring, should have specific training and skills in the post-operative care and treatment of women. (July 2005)	Healthcare Commission reports: Nurses trained in caring for patients recovering from an anaesthetic, and operating theatre nurse have also been employed. *(p. 107)* (August 2006)	Healthcare Commission, 'Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April 2005' (August 2006)	
Improving patient safety	**12**	An audit plan for maternity services should be developed with topics identified as a result of learning from incidents, complaints, and national priorities for maternity services. Findings from audits must be widely communicated and used to influence and change practice. (July 2005)	The Trust adopted the recommendation into its May 2005 action plan under Actions 15.1, 15.2, 15.3, and 15.4. Unable to locate evidence of full completion.	Healthcare Commission, 'Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April	

Inquiry into Northwick Park, North West London Hospitals NHS Trust					
				2005' (August 2006)	
Staff in the maternity services					
Improving patient safety	**13**	Urgent action must be taken in response to the results of the review of midwifery staffing to address the identified shortage of midwives. A workforce development plan must also be agreed to meet current and future needs of the service. (July 2005)	Healthcare Commission reports: an additional 20 midwives have been recruited. *(p. 107)* The Trust adopted the recommendation into its May 2005 action plan under Actions 5.1, 5.2, 5.3, 5.4, and 5.5. This includes the workforce development plan, but unable to locate evidence of full implementation. (August 2006)	Healthcare Commission, 'Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April 2005' (August 2006)	
Improving NHS culture and governance	**14**	A full time consultant obstetrician should provide clinical leadership on the labour ward, particularly for women assessed as being at high risk. Cover by consultants on the labour ward should also be increased to 60 hours per week in accordance with the guidelines of the Royal College of Obstetricians and Gynaecologist. (July 2005)	Trust improved in the recruitment of three additional consultant obstetricians. The level of cover by consultants on the labour ward has been increased from 40 hours to 60 hours between Monday and Friday. *(p. 107)* (August 2006)	Healthcare Commission, 'Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between	

Inquiry into Northwick Park, North West London Hospitals NHS Trust					
				April 2002 and April 2005' (August 2006)	
Improving NHS culture and governance	**15**	A programme of change should be developed and implemented to eliminate bullying in maternity services and to ensure that staff work effectively together. (July 2005)	Healthcare Commission reports: More effective teamwork and improved communication in the consultant obstetric team, and between obstetric staff and midwives. The Trust adopted the recommendation into its May 2005 action plan under Actions 7.1, 7.2, 7.3, and 7.4. However, unable to locate evidence of implementation. (August 2006)	Healthcare Commission, 'Investigation into 10 maternal deaths [etc.]' (August 2006)	
Improving NHS culture and governance	**16**	Attendance at mandatory training must be improved and a service wide system of access to post-registration training implemented with effective record keeping. (July 2005)	The Trust adopted the recommendation into its May 2005 action plan under Actions 8.1, 8.2, 8.3, and 8.4. Unable to locate evidence of full completion.	North West London Hospitals NHS Trust, 'Action plan arising from a responsive review of Maternity Services by the Healthcare Commission and from Special Measures' (May 2005)	
Outcomes from care and treatment, and the experiences of women					

Inquiry into Northwick Park, North West London Hospitals NHS Trust					
Improving NHS culture and governance	**17**	Ways of communicating with women and their families must be improved, especially with the black and minority ethnic population served by the trust. This should include listening to and acting on the views of women as well as providing appropriate information and rapid access to translation services. (July 2005)	The Trust adopted into May 2005 action plan under Actions 1.3 and 1.4. Unable to locate evidence of full completion.	North West London Hospitals NHS Trust, 'Action plan arising from a responsive review of Maternity Services by the Healthcare Commission and from Special Measures' (May 2005)	
Improving NHS culture and governance	**18**	All staff in maternity services must attend the trust's cultural awareness training within the next six months. (July 2005)	The Trust adopted into May 2005 action plan under Actions 2.1 and 2.2. Unable to locate evidence of full completion.	North West London Hospitals NHS Trust, 'Action plan arising from a responsive review of Maternity Services by the Healthcare Commission and from Special Measures' (May 2005)	
Improving the ability to raise complaints and concerns	**19**	All complaints should be responded to in a timely and sensitive way, in line with the trust's existing policy. There should be regular analysis of themes arising from both written and verbal complaints and	The Trust adopted into May 2005 action plan under Actions 2.1 and 2.2. Unable to locate evidence of full completion.	North West London Hospitals NHS Trust, 'Action plan arising from a responsive review	

Inquiry into Northwick Park, North West London Hospitals NHS Trust					
		action plans developed to ensure that the whole of maternity services learns from them. (July 2005)		of Maternity Services by the Healthcare Commission and from Special Measures' (May 2005)	
	20	There should be a review of all equipment used in maternity services and effective systems of maintenance put in place. (July 2005)	Healthcare Commission reports: *"Replacement of defective equipment and implementation of a system for the maintenance of equipment." (p. 107)* (August 2006)	Healthcare Commission, 'Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April 2005' (August 2006)	
National Recommendations					
	21	The Healthcare Commission recommends that the Department of Health, in collaboration with the Health and Social Care Information Centre and professional bodies, drives forward the development and implementation of a national dataset for maternity services. This should	The Department of Health responds in action plan dated July 2005, records implementation of recommendation. The national service frameworks published in 2004 committed to the development of the maternity dataset and in July 2005 reported that the Department and the Health	'Department Of Health Action Plan' (July 2005)	

Inquiry into Northwick Park, North West London Hospitals NHS Trust					
		complement the national programme for the use of information technology in the NHS. (July 2005)	and Social Care Information Centre are currently working on a project for the development of this maternity dataset.		
National Recommendations – August 2006 Report					
Improving patient safety	**n/a**	• The Healthcare Commission realises that, due to a shortage of suitably trained radiologists, it is not possible to provide full time cover for interventional radiology in all obstetric units. However, given the potential to save the lives of patients who have catastrophic postnatal bleeding, trusts with delivery units should, where feasible, engage with their neighbouring trusts to discuss the formation of networks. The aim should be to provide an emergency interventional radiology service that is responsive to patients' needs wherever and whenever they arise. • All NHS trusts providing maternity services, and organisations responsible for the monitoring of the performance of NHS trusts, must ensure they have robust systems in place for the monitoring of the quality and performance of the maternity services. (August 2006)	Mary Wells, North West London Hospitals NHS Trust Chief Executive in news article. *"Whilst the report does not make any suggestions for further action by this Trust specifically, we have taken on board the two national recommendations. Robust systems are already in place to monitor the quality and performance of the Trust's maternity services."* Other than the trust's response, unable to locate a national or government response in order to action the response. (August 2006)	North West London Hospitals, 'NWLH welcomes Healthcare Commission's second report into maternity services' (23 August 2006)	

11 THE KERR/HASLAM INQUIRY

11.1 Introduction

A Committee of Inquiry commissioned by the Secretary of State for Health in July 2001 to investigate how the NHS handled allegations about the conduct of William Kerr and Michael Haslam. The Inquiry was chaired by Nigel Pleming QC. The report of the Inquiry was delivered in July 2005. The report can be viewed online.

William Kerr and Michael Haslam were consultant psychiatrists convicted in 2000 and 2003 respectively of indecent assault. The victims were vulnerable female psychiatric patients. The Inquiry asked:

- Why were the voices of the patients and former patients of William Kerr and Michael Haslam not heard?
- Why were so many opportunities to respond and investigate missed?
- Why did abuse of patients go undetected for so long?
- To make recommendations as to improvements which should be made to the policies and procedures in place within the health service.

The Inquiry stated the story was one of management failure, failed communication, poor record keeping and a culture where the consultant was all-powerful. The Inquiry identified root causes categorised under five headings: (i) organisational failures, including a lack of formal process for supporting patients and repeated changes in NHS hospital and management structures; (ii) cultural issues, including prime loyalty to medical colleagues, failures to investigate and patient fears of adverse consequences; (iii) structural problems, including consensus management and a separation of domains; (iv) professional practice issues, including an absence of multi-disciplinary working and a willingness to resolve issues through retirement or transfer and; (v) individual failings, amongst those who failed to report or act upon concerns or complaints.

The Inquiry made 74 recommendations. The Government responded to the report of the Inquiry, and the recommendations it made, in its February 2007 report titled '*Safeguarding Patients: The Government's response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries*'.

11.2 Kerr/Haslam Inquiry: Table of Recommendations

Kerr/Haslam Inquiry					
Type of Recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
Improving patient safety	**1**	One of the referees in any job application should be the consultant who conducts the applicant's appraisal, their Clinical Director, or their Medical Director. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said it would invite NHS Employers to reflect this principle in updated guidance to employers.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**2**	Procedures and policies should be put in place, within twelve months of the publication of this Report, to ensure that all NHS organisations are aware of the therapies being undertaken by all staff, particularly those where patients believe clinical governance committees should be aware of them and making decisions about their use. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said that it agreed that clinical governance committees should be aware of 'all new and unorthodox treatments' in use within their organisation. The Department of Health said it would shortly be issuing revised guidance to clinical governance committees on the steps needed to ensure patient safety in adopting innovating treatments.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

Kerr/Haslam Inquiry					
Improving patient safety	**3**	Within mental health services no member of the health care team should be permitted to use or pursue new or unorthodox treatments without discussion and approval by the team (such approval to be recorded in writing). (July 2005)	In the February 2007 Safeguarding Patients report, the Government referred to its response to Recommendation 2. The Government said that where care was delivered on a team basis, clinical governance committees would wish to assure themselves that proposals to use new therapies were supported by the consensus view of the team. (February 2007)	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**4**	In relation to such identified "new or unorthodox treatments", patients should be given written explanations of the treatments, and why their use is appropriate. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said it agreed that patients needed appropriate information to give informed consent to any treatment and that this was particularly important for new or unorthodox treatments. The Department of Health said it would shortly be issuing revised guidance covering this.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**5**	The full range of physical, psychological and complementary therapies used by mental health professionals should be recorded and discussed through appraisal/job plans. Trusts should have a clear evidence base and protocols for guiding the use of these treatments. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said that where a mental health professional was using a new or unorthodox therapy they would expect this to be discussed at appraisal, and would ensure that this principle was covered in guidance to be shortly issued.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman	

Kerr/Haslam Inquiry					
				Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	6	The NHS should reconsider whether or not statutory regulation should be extended to cover hypnotherapy. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said hypnotherapy was not a discrete profession in its own right but rather a technique used by a variety of disciplines. The Government said it intended to introduce statutory regulation for some of the better established psychological disciplines.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**7**	When appointments to the NHS are considered, references should be obtained from the three most recent employers and those references should be properly checked. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said that it agreed panel chairmen should always be alert to the possibility of misleading references, and would ask NHS Employers to consider how this principle could be reflected in updated guidance. Current NHS Employers Guidance does not require references to be obtained from the three most recent employers.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

Kerr/Haslam Inquiry					
				Inquiries, February 2007.	
Regulation and oversight of NHS managers	**8**	The Department of Health should develop and publish a specific policy, with practical guidance on implementation, to guide NHS managers in their handling of allegations or disclosure of sexualised behaviour. The policy should address the various issues and difficulties set out above and include examples of good practice, as well as the extended range of options for action that could be applied; where advice and assistance can readily be provided; guidance on record-making and keeping. The guidance should also include a range of preventative measures (for example, specific accessible information for patients on what they should and should not expect in consultations, and who they can speak to for confidential advice and assistance). (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said it was asking the Council for Healthcare Regulatory Excellence to progress these as part of a project involving voluntary organisations, healthcare and professional regulatory bodies and NHS and professional organisations.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**9**	In relation to disclosures of alleged abuse, voluntary advocacy and advice services (independent of the NHS) should be supported by central public funding to offer advice and assistance to patients and former patients (particularly those who are mentally unwell, or who are otherwise vulnerable). (July 2005)	In the February 2007 Safeguarding Patients report, the Government said all Independent Complaints Advocacy Service advocates had received mental health awareness training and an increasing number had received specialised training in order to support clients with allegations of abuse. The service specification for the delivery of Independent Complaints Advocacy Service services was said to now require the provision of training in these issues.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

Kerr/Haslam Inquiry					
Improving patient safety	**10**	All Trusts should develop, within their Code of Behaviour, guidance to reduce the likelihood of sexualised behaviour, that is incorporated into the contracts of employment of those staff, or contracts of engagement for all other persons providing mental health services within the NHS. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said that guidance for professionals and healthcare organisations on how to minimise the risk of boundary violations in all therapeutic situations, including mental health services, would be developed as part of the Council for Healthcare Regulatory Excellence project.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Clear sexual boundaries between healthcare professionals and patients, CHRE, January 2008	
Improving the ability to raise complaints and concerns	**11**	Regarding mental health services, the NHS should review the cut-off period for registering a complaint, as well as the criteria for initiating an investigation of an old complaint and the procedures to be applied. (July 2005)	The Government agreed with this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said that its review of the complaints procedure would cover this. Regulation 12 of the Local Authority Social Services and National Service Complaints (England) Regulations 2009 amended the time period to 12 months, with a discretionary power to disapply that period.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

Kerr/Haslam Inquiry					
				Inquiries, February 2007. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009	
Improving the ability to raise complaints and concerns	**12**	Protocols should be established to ensure that psychiatric patients who raise concerns or complaints in relation to allegations of abuse are not treated in ways which are less favourable than the treatment advised for vulnerable or intimidated witnesses within the framework of "Achieving Best Evidence" (Action For Justice, 2002). Such psychiatric patients should be treated with care, consideration and integrity. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said this should apply to all disciplines. It said this would be covered in its review of the complaints procedure.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	13	Because medical procedures that require benzodiazepines to be given intravenously (e.g. oral endoscopy and induction of anaesthesia) are potentially high risk in terms of false sexual fantasies and allegations, these should always be chaperoned. (July 2005)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said intravenous benzodiazepines might sometimes be needed in emergencies when a chaperone might not be available. The Government said that it would cover this in any further updates of general NHS guidance on chaperones.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

Kerr/Haslam Inquiry					
				Inquiries, February 2007.	
	14	Trusts' confidentiality policies should include a section on disclosure within therapeutic interactions in psychiatric practice and should be supported by inter-agency information-sharing policies to be used in all cases of patient abuse. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said that the Department of Health was developing guidance in the area which it hoped to issue in spring 2007.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**15**	Dedicated staff should be properly trained to carry out the investigations. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said existing standards already required healthcare organisations to operate effective systems for handling complaints, as this would be considered as part of the review of the health complaints systems.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	16	The Secretary of State, within 12 months of the publication of this Report, should commission and publish guidance and issue advice and instruction	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said that the Department of Health was	Safeguarding Patients: The Government's	

Kerr/Haslam Inquiry					
		(preferably in consultation with the professional regulatory bodies and healthcare Colleges) as to the meaning and limitations of patient confidentiality in mental health settings. Such guidance should be kept under regular review. (July 2005)	developing guidance in the area which it hoped to issue in spring 2007.	Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**17**	The NHS should convene an expert group to consider what boundaries need to be set between patients and mental health staff who have been in long-term therapeutic relationships, and how those boundaries are to be respected in terms of guidelines for the behaviour of health service professionals, and the provision of safeguards for patients. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said this would be covered as part of the Council for Healthcare Regulatory Excellence project. In January 2008, the Council for Health Regulatory Excellence published guidance for healthcare professionals on sexual boundaries between healthcare professionals and patients.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**18**	Detailed, and readily accessible, guidance should be developed for medical professionals. The guidance should be framed in terms which address conduct which will not be tolerated and which is likely to lead to disciplinary action. Such guidance, if not provided at a professional regulatory level, should be supplemented by the NHS at an employment level. (July 2005)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said this would be covered as part of the Council for Healthcare Regulatory Excellence project. In January 2008, the Council for Health Regulatory Excellence published guidance for healthcare professionals on sexual boundaries between healthcare professionals and patients.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations	

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				of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Clear sexual boundaries between healthcare professionals and patients, CHRE, January 2008	
Improving patient safety	**19**	Policies should be developed that enable health workers to feel able to disclose feelings of sexual attraction at the earliest stage possible without the automatic risk of disciplinary proceedings. Colleagues must also feel able to discuss openly and report concerns about the development of attraction/overly familiar relationships with patients. These policies should include all grade levels, including consultant. (July 2005)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said this would be covered as part of the Council for Healthcare Regulatory Excellence project. In January 2008, the Council for Health Regulatory Excellence published guidance for healthcare professionals on sexual boundaries between healthcare professionals and patients. This included guidance for when a health professional developed sexual feelings towards a patient, saying in such circumstances they should seek advice as to what course of action to take, and consider finding alternative care for the patient.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Clear sexual boundaries between healthcare professionals and patients, CHRE, January 2008	

Kerr/Haslam Inquiry					
Improving patient safety	**20**	The Secretary of State, within 12 months of the publication of this Report, should convene an expert group to develop guidance and best practice for the NHS on boundary setting, boundary transgression, sexualised behaviour, and all forms of abuse of patients, in the mental health services. (July 2005)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said this would be covered as part of the Council for Healthcare Regulatory Excellence project. In January 2008, the Council for Health Regulatory Excellence published guidance for healthcare professionals on sexual boundaries between healthcare professionals and patients.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	21	The terms of reference of the expert group should not be restricted to sexualised behaviour between psychiatrists (or other mental healthcare professionals) and current patients, but should also address former patients. (July 2005)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said this would be covered as part of the Council for Healthcare Regulatory Excellence project. In January 2008, the Council for Health Regulatory Excellence published guidance for healthcare professionals on sexual boundaries between healthcare professionals and patients.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	22	There should be detailed research carried out and published by the Department of Health to show the prevalence of sexual assaults, sexual contact, or other sexualised behaviour, between doctors and existing and/or former patients – particularly in the field of mental health. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said that the Council for Healthcare Regulatory Excellence project would review current research on the profile of people perpetrating boundary violations. The Government said that in light of the review, the Department of Health would consider whether to	Safeguarding Patients: The Government's Response to the recommendations of the Shipman	

Kerr/Haslam Inquiry					
			commission further research on the prevalence of sexualised behaviour.	Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**23**	The Department of Health should urgently investigate and report upon the need for a co-ordinated method of mandatory data collection and mandatory recording, in relation to the area of abuse of patients by mental healthcare professionals. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said that the Department of Health would encourage professional regulators to carry out a retrospective analysis of recent fitness to practise cases to determine in what proportion boundary violations had been a factor. The Department of Health was also to consider whether the information received from reports of serious untoward incidents could be categorised so as to allow routine analysis of this kind.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	24	Mental health services should provide routine information to patients attending appointments on what to expect from a consultation with a mental health professional. This should apply to consultations in all settings, including home visits. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said that for conventional therapies, it was reasonable to expect the referrer to describe in broad terms the likely assessment and therapeutic purpose of the consultation. Where a novel or unusual therapy was to be offered, the Government agreed that patients should receive a full written explanation in advance.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

Kerr/Haslam Inquiry					
				Inquiries, February 2007.	
Improving patient safety	**25**	Where physical contact forms part of the consultation, or where there is a risk of loss of consciousness, there should be a national policy and implementation guidelines to safeguard patients and staff and support the maintenance of appropriate boundaries. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said this would be covered as part of the Council for Healthcare Regulatory Excellence project.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving NHS culture and governance	**26**	The NHS should review current records management practice and ensure that a robust set of systems and practices are uniformly applied across the service. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said that it agreed that clinical records should be made at or close to the time of the original consultation, and any subsequent amendments be clearly documented. The Department of Health was to ask the professional regulators to ensure their ethical guidance underlined the importance of accurate clinical records.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise	**27**	Within 12 months of publication of this Report, the Department of Health should issue guidance as to how and where any disclosure or complaint of	This recommendation was accepted in principle by the Government.	Safeguarding Patients: The Government's	

Kerr/Haslam Inquiry					
complaints and concerns		abuse by another healthcare professional made to a doctor or nurse should be recorded (if at all) in the patient's medical records, and elsewhere. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said the Department of Health would work with stakeholders to develop guidance on the content of the files to be held by healthcare organisations relating to performance of individual professionals, including complains and concerns. The Government's view was that it would not normally be appropriate for such information to be held in the patient's clinical records and the Department of Health would consider whether further guidance was needed on this point.	Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**28**	A protocol should be produced, and guidance issued within 12 months of the publication of this Report regarding the collection, collation and retention of data in relation to concerns and complaints covering sexualised conduct by mental health professionals – including, but not restricted to: a. The name of the mental health professional; b. The details of the concern or complaint; c. The date of the alleged sexualised behaviour; d. The date of the concern or complaint; e. If investigated, by whom and with what outcome; f. If not investigated, the reason. (July 2005)	This recommendation was accepted in principle by the Government. In the February 2007 Safeguarding Patients report, the Government said the Department of Health would work with stakeholders to develop guidance on the content of the files to be held by healthcare organisations relating to performance of individual professionals, including complaints and concerns.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**29**	Consideration should be given to the retention period of such data, stating our preference (subject to the advice of the Information Commissioner, and the terms of the Human Rights Act 1998) that such data be retained for the lifetime of the mental health	This recommendation was accepted in principle by the Government. In the February 2007 Safeguarding Patients report, the Government said the Department of Health would work with stakeholders to develop guidance on the content of the files	Safeguarding Patients: The Government's Response to the recommendations	

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		professional. All NHS staff should be made aware regularly that this data is collected and retained. (July 2005)	to be held by healthcare organisations relating to performance of individual professionals, including complaints and concerns.	of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**30a**	The current regulations relating to complaints procedures should be amended to enable any person with a concern about the safety and effectiveness of the NHS to be allowed more readily to use the NHS complaints procedure. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said it agreed that the complaints procedures should be as simple as possible for patients and their representatives to us use. As to those with a generalised rather than personal concern about safety and effectiveness of the NHS, the Government said that a number of routes were available, including the Patient Advice and Liaison Service. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 permitted a complaint to be made by a person who receives/has received services from a responsible body, or a person who is (likely to be) affected by the action, omission or decision of the responsible body concerned.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009	
Improving the ability to raise complaints and concerns	**30b**	Further the time limit applicable from the incidents complained of and the complaint being made should be relaxed. (July 2005)	The Government agreed with this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said that its review of the complaints procedure would cover this.	Safeguarding Patients: The Government's Response to the recommendations	

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			Regulation 12 of the Local Authority Social Services and National Service Complaints (England) Regulations 2009 amended the time period to 12 months, with a discretionary disapplication of that period.	of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009	
Improving the ability to raise complaints and concerns	**31**	The Department of Health should review the effectiveness of whistleblowing policies and initiatives within NHS-funded organisations. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said it agreed with the need to support and protect all those wishing to raise concerns about the actions of a healthcare colleague. The Government proposed that all organisations providing services to the NHS should have a written policy setting out the procedure to be followed by staff wishing to raise concerns, and said it would be discussing with stakeholders how this might be best be achieved. The Government also said it would discuss with stakeholders the role of primary care trusts and local medical committees in this context.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**32**	As a matter of some urgency the NHS should clarify the context of the positive obligation of NHS staff to inform NHS management of concerns in relation to the suspicion of the abuse of patients (July 2005)	In the February 2007 Safeguarding patients report, the Government said that this principle was already covered in ethical guidance from the professional regulators and from the National Clinical Assessment Authority. The Government said it would discuss with professional	Safeguarding Patients: The Government's Response to the recommendations	

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			regulatory bodies how this duty could be further emphasised.	of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**33**	Policies and guidance should be drawn up to clarify the obligation to investigate (certainly in the case of suspicion of the abuse of possibly vulnerable patients) without the need for a complaint from, or that identifies, a particular named patient. (July 2005)	The Government agreed with this recommendation. In the February 2007 Safeguarding Patients report, the Government said the Department of Health would consider with the NHS and other stakeholders what further guidance would be helpful.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**34**	The NHS should, jointly with the appropriate National Standards bodies, produce a standardised complaints system to be implemented in all Trusts/ organisations providing services to NHS patients. (July 2005)	In the February 2007 Safeguarding patients report, the Government said it agreed that the complaints system should be as far as possible integrated across health and social care. The Government said this would be considered as part of the Council for Healthcare Regulatory Excellence project.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

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				Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**35**	Themes and trends arising from the data of complaints, incidents, patient and carer feedback should be analysed on a regular basis. This should form part of clinical governance and used to give early warning of emerging patterns of risk behaviour, in the interests of patient safety. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said the Department of Health would consider with the NHS and other stakeholders what further guidance would be helpful.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**36**	Information about the NHS complaints procedure and its relationship to other forms of regulation and clinical governance should be explained to all staff during their induction process and form a core part of continuing professional development programmes. This should include advice and training on how to deal with distressed and angry patients who want to make a complaint. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said it would consider the best way of promoting awareness of complaints handling procedures in all NHS staff as part of work on common standards for initial handling and rerouting of complaints.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise	**37**	Frontline staff who receive complaints about issues which compromise patient safety – whether or not in the confines of a therapeutic disclosure – should	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said that this principle was already covered in	Safeguarding Patients: The Government's	

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complaints and concerns		be under an express obligation to report that matter to a complaints manager (in or beyond their own organisation) whether or not they work for the organisation named in the complaint. (July 2005)	ethical guidance from the professional regulators and from the National Clinical Assessment Authority. The Government said it would consider the best way of promoting awareness of complaints handling procedures in all NHS staff as part of work on common standards for initial handling and rerouting of complaints.	Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**38**	Health and social care commissions should resource independent mental health advocacy as a priority. (July 2005)	In the February 2007 Safeguarding Patients report, the Government referred to the importance of the Patient Advice and Liaison Service and its response to Recommendation 9. The Government did not address the priority of independent mental health advocacy more generally.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**39**	Patient Advice and Liaison Service and complaints staff should be actively linked into a clinical governance and information sharing network with regular access to data on performance issues drawn from such things as claims, patient satisfaction surveys, audit and peer review. (July 2005)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said the Department of Health would discuss with stakeholders the ways in which information relating to the performance of individual professionals could be shared within and between health organisations. For doctors, information relating to substantiated concerns would be held on the General Medical Council Register and	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations	

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			accessible to appropriate individuals in accredited healthcare organisations.	of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**40**	Patient Advice and Liaison Service and complaints staff should have direct access to a line manager at board level and to senior medical staff and that they should be appointed at middle management level. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said this would be considered as part of the review of complaints procedures.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**41**	The roles of complaints officer and Patient Advice and Liaison Service officer should be distinct. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said this would be considered as part of its review of complaints procedures.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving the ability to raise complaints and concerns	**42**	The Department of Health should introduce permanent arrangements for the provision of independent advice for mental health patients. (July 2005)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government referred to the majority of Independent Complaints Advocacy Service advocates as having had specialist training in mental health issues.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**43**	The Department of Health should be responsible for ensuring a standardised training programme for Patient Advice and Liaison Service and NHS complaints staff. (July 2005)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said that training courses were already available and that the Department of Health was setting up a national network to enable complaints staff to share best practice. The Department of Health said it would work with stakeholders to determine what other steps might be needed.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**44**	Those who are given the task of responding and initiating any investigation should themselves be adequately trained, equipped with the necessary skills to carry matters forward, and of such seniority as to ensure that barriers and resistance are overcome. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said that training courses were already available and that the Department of Health was setting up a national network to enable complaints staff to share best practice. The Department of Health said it would work with	Safeguarding Patients: The Government's Response to the recommendations of the Shipman	

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			stakeholders to determine what other steps might be needed. The Government said that for more complex investigation or those involving more serious investigations, front-line NHS organisation might wish to call on additional resources.	Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**45**	The revised regulations should require that all formal complaints should be directed to designated complaints managers in primary care trusts and NHS Trusts. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said that the Department of Health would develop standards to ensure that complaints, wherever received, were speedily routed to the most appropriate organisation (and to the complaints manager in that organisation). In primary medical care, the Government proposed allowing patients or their representatives to make complaints directly to the primary care trust. Regulation 4 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 required each responsible body to designate a complaints manager, responsible for managing the procedures for handling and considering complaints.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009	
Improving the ability to raise complaints and concerns	**46**	Formal complaints should be interpreted as any matter which the complainants would like to be treated as formal. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said that this was already the formal position, but that it would consider in its wider review of the complaints system how to promote greater awareness.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman	

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				Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**47**	Current regulations should be amended to ensure that it is the duty of complaints officers to investigate complaints in a speedy, efficient and effective manner. (July 2005)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, however, the Government said it considered that it was more important to ensure that handling of complaints achieved desirable outcomes than to meet rigid targets for response times. The Government said this would be covered in its review of the complaints handling process. Regulation 3 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 required arrangements for the handling and consideration of complaints to be such as to ensure that complaints were dealt with efficiently, properly investigated and received a timely and appropriate response.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009	
Improving the ability to raise complaints and concerns	**48**	Current regulations should be amended to require complaints managers to consider the implications for clinical governance and patient safety of all complaints received. Where a clinical governance issue arises this should be reported to their line manager and to the board. (July 2005)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said this would be covered in the wider review of complaints handling, in particular the proposed	Safeguarding Patients: The Government's Response to the recommendations of the Shipman	

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			strengthening of the national standards for complaints handling. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 did not make provision for this.	Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009	
Improving the ability to raise complaints and concerns	**49**	Current regulations should be amended, and suitable guidance prepared, to allow and ensure that complaints managers consider the reference of any complaint received which, if true, would disclose the commission of a crime, to the local police force. (July 2005)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government referred to the Memorandum of Understanding agreed between the Association of Police Officers, the NHS and the Health and Safety Executive in February 2006, setting out the responsibilities and roles of each party, procedure for liaison, clarity over responsibility for initial investigation, sharing information and supporting those harmed, other patients, relatives and NHS staff. The Government did not refer in its response to amendment of regulations or preparation of guidance. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 did not make provision for this.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Memorandum of Understanding: Investigating patient safety incidents involving unexpected death	

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				or serious untoward harm, Department of Health, ACPO, HSE, February 2006. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009	
Improving the ability to raise complaints and concerns	**50**	Current regulations should be amended to require complaints managers to take statements from all those staff involved in the investigation of the complaint. (July 2005)	The Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said this would be covered in the wider review of complaints handling, in particular the proposed strengthening of the national standards for complaints handling. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 did not make provision for this.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009	
Improving the ability to raise	**51**	Guidance issued under the regulations should clarify what constitutes a full and rigorous	The Government accepted this recommendation in principle.	Safeguarding Patients: The	

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complaints and concerns		investigation, most notably that complaints officers be placed under a duty to raise additional issues for investigation. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said this would be covered in the wider review of complaints handling, in particular the proposed strengthening of the national standards for complaints handling.	Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**52**	All NHS staff should be placed under an obligation to co-operate with investigations carried out by complaints managers. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said that all NHS Employed staff were required to comply with the reasonable requests of their employer and were expected to comply with local procedures for the investigation of complaints, critical incidents or concerns about employees. The Government said the Department of Health would discuss with stakeholders how these duties could be reinforced through ethical guidance from the professional regulators.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**53**	Where possible, the NHS should give clear advice and guidance on employment protocols following allegations of abuse. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said this would be considered as part of the Council for Healthcare Regulatory Excellence project.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the	

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				recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**54**	Chief Executives acting on the advice of their complaints managers should be given the authority to refer a complaint to the Healthcare Commission for further consideration. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said it was not convinced that front-line healthcare organisations should have an automatic right to refer complex complaints to the Healthcare Commission for further consideration. However, the Government considered that, where initial investigation suggested some deeper structural problems, the organisation might wish to alert the Healthcare Commission, which might in turn decide to investigate.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**55**	Complainants should be allowed to pursue litigation at the same time as a complaint is being investigated. (July 2005)	This recommendation was accepted by the Government. In the February 2007 Safeguarding Patients report, the Government said that (threat of) legal proceedings should not prevent a primary care trust or an employer from continuing to investigate a complaint, provided they could do so without prejudicing the proceedings. The Government said it would give further guidance on this point.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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Improving the ability to raise complaints and concerns	**56**	The Department of Health should convene a working party to consider what information it is necessary to record about complaints in order for them to be of use in clinical governance and the circumstances and form in which it is appropriate to record suspicions. (July 2005)	The Government agreed with this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said that the Department of Health would develop guidance on this as part of the wider guidance on the content of files on individual professionals.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**57**	In line with the recommendations of the Shipman Inquiry, a centralised database should be set up which is capable of recording a range of information about the performance of individual doctors. (July 2005)	The Government agreed with this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said that, for doctors, the General Medical Council register would act as the central depository of information on the registration status of doctors, together with any related information including disciplinary action by employers and alert notices.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**58**	Regulatory bodies (with responsibility for the regulation and discipline of psychiatrists and other mental healthcare professionals) and the Department of Health should be under a clear duty, in the public interest, to share information about disciplinary investigations or other related	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said that the Department of Health would discuss with stakeholders the concept of a 'duty of collaboration' which would require healthcare organisations (including professional regulators) to share information	Safeguarding Patients: The Government's Response to the recommendations of the Shipman	

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		proceedings. This duty should extend to information known to the regulatory bodies and the Department of Health relating to disciplinary investigations and related proceedings, even if conducted outside the United Kingdom. Consideration should be given to the collection and retention of all information relevant to patient safety, including unsubstantiated complaints, unproven allegations and informal concerns. (July 2005)	about individual professionals where needed to protect patient safety. The Government said that the Medical Act already required the General Medical Council to disclose information to the Department of Health and employers at the point at which they began to investigate a case, and this was now routine practice.	Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**59a**	The Department of Health should clearly state what information can be included in relation to electronic staff records relating to complaints, proven/ unproven incidents, disciplinary investigations and findings. Such a record should be established in standard form and, once established, should move with the individual to reduce the risk of staff evading detection of past misdemeanours. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said that the Department of Health would develop guidance on this as part of the wider guidance on the content of files on individual professionals.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**59b**	The Department of Health should consider whether or not, and if so how and in what circumstances, any such information should be transferable between the NHS and the private sector. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said this would be covered in the discussion with stakeholders on information sharing.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale	

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				and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**60**	The Department of Health in association with the National Institute for Mental Health in England and the Royal College of Psychiatrists should publish guidance in relation to clinical supervision of consultant and career grade psychiatrists. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said it did not accept that the risks associated with autonomous clinical practice were different in kind for psychiatry as compared to other clinical disciplines, and general safeguards would be sufficient.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**61**	Any deviation from acceptable practice [in applying the principles of the new disciplinary framework for doctors] in mental health services should be identified by the relevant statutory regulatory body and, where appropriate, by Monitor, and a standard, fair and transparent set of rules governing conduct of all mental health NHS staff in all NHS bodies and Foundation Trusts be quickly established. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said that trust boards had the primary responsibility of ensuring the good practice in relation to the new disciplinary framework for doctors was applied throughout the trust. Where the Healthcare Commission identified any significant deviations, the Government said it would expect them to draw this to the attention of the trust board and to Monitor or the strategic health authority.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**62**	The Secretary of State should invite the Council for Healthcare Regulatory Excellence to consider (with	In the February 2007 Safeguarding Patients report, the Government said that the Council for Healthcare	Safeguarding Patients: The	

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		a grant of additional powers if necessary), in relation to the regulation of healthcare professionals, the application of common standards, practices and procedures so that patient safety can more effectively be protected. (July 2005)	Regulatory Excellence's role already included the development of common standards and processes across the health professional regulators, which was likely to be an increasingly important part of their activities.	Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**63**	Within 12 months of the publication of this Report the Department of Health should develop and publish national advice and guidance to Primary and Secondary Health Care Trusts addressing the action to be taken by staff on the disclosure of sexual, or other, abuse by patients or other service users, with particular emphasis on users of mental health services. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said that it would ask the Council for Healthcare Regulatory Excellence to progress these as part of a project involving voluntary organisations, healthcare and professional regulatory bodies and NHS and professional organisations.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	64	The GP curriculum should be reviewed to ensure that sufficient focus is given to the needs, treatment and care of patients experiencing mental health problems and illnesses and that all GPs should have some exposure to psychiatry. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said it would discuss this recommendation with professional and educational interests.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the	

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				recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
	65	Mental health issues should be part of the Nursing and Midwifery Council Foundation Year 2. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said it would discuss this recommendation with professional and educational interests.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**66**	Early consideration should be given to extending the remit of the National Clinical Assessment Service to cover other healthcare professionals, particularly those providing care and treatment in mental health services. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said that the Department of Health and the National Clinical Assessment Service were considering the possible extension of the latter's remit to other professions.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

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	67	The NHS should review the curriculum content – at all education and training levels – to ensure that medical practitioners are able to undertake appropriate cross-sector working (including within NHS i.e. primary/ secondary boundary) as part of their practice. (July 2005)	This Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said that it would consider with educational and professional interests what more could be done.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**68a**	Those responsible for developing the curricula for education programmes of healthcare professionals should ensure that information about and discussion of the ethical responsibilities of healthcare professionals to bring poor performance to light is given due weight. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said it would discuss with professional regulatory bodies and universities how this duty could be further emphasised, particularly in undergraduate education.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving NHS culture and governance	**68b**	Those responsible for developing the curricula for education programmes of healthcare professionals should ensure that students are made aware of: forms of regulation and clinical governance operating in the NHS and the ethos which underpins them; the relationship between the	This Government accepted this recommendation in principle. In the February 2007 Safeguarding Patients report, the Government said it would discuss this recommendation further with educational and NHS interests.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman	

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		different systems; and how they can be accessed. (July 2005)		Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**69**	Professional training includes: compulsory education and training on the maintenance of professional boundaries, awareness of boundary transgressions, sexualised behaviour as unethical conduct, response to expressions of concerns and complaints, complaints' systems, what to do if a complaint is made but the person making the complaint declines to take an active part in a formal complaint, as well as the requirements of, and limitations on, patient confidentiality. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said this would be covered in the professional guidance developed as part of the project undertaken by the Council for Healthcare Regulatory Excellence.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving the ability to raise complaints and concerns	**70**	The NHS should adopt and reinforce the recommendations in the Manzoor Report and in Making Amends, that there should be a duty of candour imposed on, and accepted by, NHS staff. This duty would mean that there is a responsibility to be proactively informative with patients and with their relatives and carers. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said that members of the medical, nursing and midwifery professions were already under a professional obligation to inform patients when things went wrong during treatment. The Government said it made clear in debates on the NHS Redress Act why it did not consider it appropriate to impose a statutory duty on top of these professional obligations, and said the Shipman Inquiry came to a similar conclusion in their Fifth Report. The Government said it would discuss with the Council for Healthcare Regulatory Excellence and the other regulators	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

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			whether a similar approach could be adopted for the other health professions. A duty of candour was subsequently implemented in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.	Inquiries, February 2007. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	
	71	In relation to private inquiries for witnesses who make statements, and/ or who give oral evidence, legal safeguards should be introduced to grant them immunity from action in relation to their evidence (whether fact or opinion), in the absence of malice. (July 2005)	The Government accepted this recommendation, which was implemented as section 37 of the Inquiries Act 2005.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007. Inquiries Act 2005	
	72	If not already appointed, a multidisciplinary committee should be established to collate, consider and report on the recommendations made in this Report, in the Shipman Report, the Neale Report, the Ayling Report, and the Peter Green Report, insofar as those reports, and the recommendations made in them relate to the common theme of handling concerns and complaints, and to patient protection. (July 2005)	The Government accepted this recommendation. In the February 2007 Safeguarding Patients report, the Government said it would establish a multi-disciplinary national advisory group to advise on the Department of Health on the implementation of its action programme.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam	

Kerr/Haslam Inquiry					
				Inquiries, February 2007.	
Improving the ability to share complaints and concerns	**73**	All Strategic Health Authorities should set up a manned telephone Helpline (perhaps called a 'PatientLine'), where anonymised (or identified) concerns could be received and processed. Any information received through the Helpline should be logged and received in confidence (unless there is express identification of the caller), and if there is sufficient information disclosed, should be discussed with the relevant NHS trust or primary care trust. Consideration should be given as to how this information could best be collated either regionally or nationally. (July 2005)	In the February 2007 Safeguarding Patients report, the Government said it believed that staff with concerns over patient safety issues should be invited in the first instance to share their concerns in confidence with local management. However, the Government said it would explore this recommendation in more detail with stakeholders.	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	
Improving patient safety	**74**	The Mental Health Trusts, together with the Primary Care Trusts, should draw up and distribute patient information leaflets, so that patients referred by their General Practitioners to the care of a consultant psychiatrist can better understand what to expect, and the circumstances if any in which the patient can expect to receive any physical examination or treatment from the psychiatrist. This leaflet information should include the following topics: a. when the patient can expect a physical examination by the psychiatrist; b. a description of boundaries, and what is and what is not acceptable behaviour by the psychiatrist; c. what the patient is likely to expect in the course of talking therapies (for example, questions and inquiries which some may consider too intrusive and intimate); d. what, if anything, is expected of the patient; e. the	In the February 2007 Safeguarding Patients report, the Government said that GPs and hospital outpatient clinics would develop information leaflets on what to expect as part of mental health consultations. The Government stated that the Department of Health was developing an Information Accreditation Scheme to raise the general standard of such information and help the public to find reliable sources of information	Safeguarding Patients: The Government's Response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007.	

Kerr/Haslam Inquiry					
		availability of trained chaperones and, if installed, the use of virtual chaperones f. the contact details of the person to whom they may turn in confidence to discuss any issue that may give them concern before, during and after treatment. (July 2005)			

12 MID CHESHIRE HOSPITALS NHS TRUST INQUIRY BY THE HEALTHCARE COMMISSION

12.1 Introduction

In June 2004 a nurse, Barbara Salisbury, was convicted of two separate charges of attempted murder of patients at the Mid Cheshire Hospitals NHS Trust. The conviction related to incidents that occurred in 2002 while Barbara Salisbury was employed on wards for older people at the trust's main site, Leighton Hospital. The incidents involved the inappropriate administration of diamorphine, a powerful opiate analgesic, to patients.

The Healthcare Commission carried out an investigation into the systems and procedures that were in place in the trust at the time of the incidents to establish whether these were appropriate to protect the safety of patients. The focus was the medical directorate at the trust and, in particular, the care of older people.

The investigation also reviewed changes made by the trust since these incidents and assess whether adequate arrangements are now in place to protect the safety of patients. The Investigation Manager was Dr Heather Wood and the investigation Report was published on 24 January 2006. The report can be viewed online.

12.2 Mid Cheshire Hospitals NHS Trust Inquiry: Table of Recommendations

Mid Cheshire Hospitals NHS Trust Inquiry					
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
Improving patient safety	**UA1**	**24 January 2006: Urgent/immediate action: T**he strategic health authority must work with the trust and the primary care trust to agree appropriate levels of nursing staff and then ensure that the trust has sufficient nurses to provide acceptable and safe care.	The Inquiry Report noted that, between the Healthcare Commission writing to the trust in May 2005 and the Inquiry Report being published in January 2006, progress had been made as follows: - The trust had recruited 44 qualified and unqualified nurses. The trust's 'Action Plan' (as at 8 March 2006) also responded to the recommendations made in the Inquiry Report by setting actions, each with intended outcomes and outcome measurements and overview from an accountable executive. The Action Plan listed actions which included: identifying the investment necessary for the recruitment and employment of additional nurses., of which £1m had been Identified for the first stage of recurrent funding to recruit 30 x healthcare assistances and 10 x band 5 qualified nurses to support Medical Directorate; recruiting staff agreed for first stage (noted as completed); identifying escalation procedures to maintain minimum nursing levels in all areas (noted as completed); introducing Nursing Strategy to develop all areas of Nursing Care (noted as 'policy approved and implementation taking place'); and reducing	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	

Mid Cheshire Hospitals NHS Trust Inquiry					
			current continued level of bank and agency staffing by 10% (noted as 'working group established').		
	UA2	**24 January 2006: Urgent/immediate action:** The trust needs to investigate and address the causes of poor clinical outcomes in the medical directorate. The necessary analysis should be completed, and implementation of necessary action started, by March 2006.	The Action Plan (as at 8 March 2006) listed actions which included: initiating review of leadership, management and accountability arrangements (noted as 'completed first stage of review'); trust to approve proposal (noted as completed); consulting on proposals by 13.02.06; implementing final proposals by 31.03.06; establishing policy for dealing with existing arrangements for clinical director contracts (noted as completed); and agreeing contractual arrangements for future clinical director contracts (noted as completed).	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	
Culture and governance	**UA3**	**24 January 2006: Urgent/immediate action: T**he trust must ensure that there are adequate governance and management arrangements in the medical directorate. This should be completed within 60 days of the publication of the report. The trust must also ensure that adequate support and management is provided to ward managers.	The Action Plan (as at 8 March 2006) noted "*Commission Mersey Internal Audit to support review of the Trust's risk assurance framework, to include clarification of committee structures, levels of decision making, knowledge-management framework, and objectives for 2006/07 and beyond. ▪ Review commissioned, and action in hand for completion by 28.2.06".*	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	
	UA4	**24 January 2006: Urgent/immediate action:** The board and the executive team must urgently review the management structures and accountability arrangements in the trust, including the directorate structures and the Investigation into Mid Cheshire Hospitals NHS Trust Investigation into Mid Cheshire Hospitals NHS Trust management of	The Inquiry report noted that: • The trust was in the process of undertaking a formal review of management. This was initiated early in 2005.	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	

Mid Cheshire Hospitals NHS Trust Inquiry					
		clinicians. This review must ensure proper accountability and governance, with due authority given to those with responsibility for clinical governance, through a formal scheme of delegation. This review should be completed by January 2006, and new arrangements should be in place by March 2006. There must be sufficient capacity in HR to ensure that proper processes are followed across the trust.	• A clinical governance strategy had been developed, and information on outcomes would be taken to the clinical governance committee. The Action Plan (as at 8 March 2006) listed actions which included: reviewing Directorate arrangements in line with reviews associated with Actions in Urgent Action 2 above; reviewing scope of Directorate Manager's post and that scope of post of Directorate Manager restricted to Medical Directorate; and improving organisation of meetings (monthly cycle); and establishing clinical leadership arrangements.		
Improving care for patients and services for older people					
	1.1	**24 January 2006:** The trust needs to give greater priority to the care of older patients in line with the National Service Framework for Older People and, in particular, to the standards for patients in hospital.	The Inquiry Report noted that: • A list of patient group directions was approved in July 2005. • A three-day course on the National Service Framework for Older People had been provided to some staff. Initially, this was targeted at healthcare assistants because they deliver most of the direct care to patients. The training was extended to qualified staff from June 2005. According to the trust, 80 people had been trained by the end of that month, and records of attendance were maintained. The Action Plan also listed actions for completion in 2005 and 2006 which included: participating in the strategic health authority audit for care of older people; participating in the National Falls audit and the Falls Management Pilot; reviewing and increasing the training programme for Older	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	

Mid Cheshire Hospitals NHS Trust Inquiry					
			People; phased implementation of the Single Assessment Process (electronic system); developing clear, defined job descriptions/roles for nursing; developing and raising awareness of 'Essence of Care'; extending the Patient Experience group to include wider multi-disciplinary involvement; and improving processes for managing complaints and concerns. See "Key Recommendation 1" in the Action Plan for full details.		
	1.2	**24 January 2006:** The trust needs to improve its information on the quality of services for older patients and ensure that it is providing person-centred care and treating patients with dignity and respect. There must be adequate numbers of nurses with appropriate skills.	The Inquiry Report noted that 44 new nurses had been recruited (see above). The Action Plan (as at 8 March 2006) repeated the actions for Key Recommendation 1. See "Key Recommendation 2" in the Action Plan for full details.	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	
	1.3	**24 January 2006:** The trust must take action to address poor care when identified.	The Action Plan (as at 8 March 2006) listed actions for completion in 2005 and 2006 based on improving processes for management of identified issues by way of: trend analysis; introducing timescales/format for Directorate investigations; escalation processes for lack of responses; and processes for monitoring action plans. See "Key Recommendation 3" in the Action Plan.	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	

Mid Cheshire Hospitals NHS Trust Inquiry					
	1.4	**24 January 2006:** The trust must improve the quality of care for all patients who are nearing the end of their lives and ensure that they have proper access to specialist care when appropriate.	The Inquiry Report noted that the pathway for the care of dying patients had been implemented across the trust and the numbers of patients using the pathway were being collected. This was intended to mean that the trust can audit the use of the pathway for all patients, not just those known to the palliative clinical nurse specialists. Twenty-eight patients were on the pathway from April to June 2005. The majority of these were from the medical directorate. An audit of the use of yellow wristbands in June 2005 showed that the system was in use on all wards. The Action Plan (as at 8 March 2006) also listed actions for completion in 2005 and 2006 which included: providing training and awareness of Care of the Dying Pathway; and actioning outcomes from quarterly audits of Care of the Elderly Pathway. See “Key Recommendation 4” in the Action Plan for full details.	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	
	1.5	**24 January 2006:** The trust must review its arrangements for providing patients with appropriate pain relief.	The Inquiry Report noted that: • A laboratory for clinical skills has been established, and a trainer has been appointed to train doctors in the use of new pumps to administer drugs for pain relief. • A tool has been developed to help nurses assess and control pain. The Action Plan (as at 8 March 2006) also listed actions for completion between 2004 and 2006 which included: introducing tamper proof syringe drivers (noted as complete as of April 2004); continuing training of new staff in use of	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	

Mid Cheshire Hospitals NHS Trust Inquiry					
			infusion pumps; continuing pain assessment training for nurses; and implementing updating Medicines Management Policy. See “Key Recommendation 5” in the Action Plan for full details.		
Addressing clinical matters and the management of beds					
	2.1	**24 January 2006:** Within 60 days of publication of this report, the trust must review the way it manages beds, to ensure that it does not compromise the quality of care for medical admissions.	The Inquiry Report noted that: • The strategic health authority and the NHS intensive support team examined the arrangements for managing beds and procedures for discharge in the trust. A discharge folder was being printed to improve information for patients. This initiative was to be piloted in October 2005. • There were plans to reconfigure the medical wards in order to allow better concentration of clinical managerial skills. The Action Plan (as at 8 March 2006) also listed actions for completion before/in 2006 which included: senior staff to audit activity using CHKS data; identifying systematically areas of poor clinical performance for Directorate review and action; reporting issues and outcomes to the Board through the Clinical Governance Committee; preparing a detailed action plan for each speciality; reviewing complement, use and location of beds across two hospital sites; devising review-related policies for bed management, infection patients and “end of life”; and defining, assessing	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	

Mid Cheshire Hospitals NHS Trust Inquiry					
			and making fully known medical staff cover at the Victoria Infirmary, Northwich . See “Key Recommendations 6 and 7” in the Action Plan for full details.		
	2.2	**24 January 2006:** The criteria for transfer between wards should be reviewed to ensure that clinical advice is taken into account fully. No patients should be transferred to the Victoria Infirmary unless they meet the criteria for transfer and there is agreed medical accountability for their care.	The Inquiry Report noted that there were plans to reconfigure the medical wards in order to allow better concentration of clinical managerial skills. The Action Plan (as at 8 March 2006) also listed actions for completion in 2006 which included: reviewing complement, use and location of beds across two hospital sites; devising review-related policies for bed management, infection patients and “end of life”; and defining, assessing and making fully known medical staff cover at the Victoria Infirmary, Northwich. See “Key Recommendations 7 and 8” in the Action Plan for full details.	Mid Cheshire report 2 (2006) Action_plan_for_Mid_Cheshire_Hospitals_NHS_trust_Healthcare_Commission_Investigation (2006)	
	2.3	**24 January 2006:** The trust must disseminate its policy on the administration of drugs and ensure that staff receive appropriate training within 60 days of the publication of this report	The Inquiry Report noted that: • A nurse had been appointed on a temporary basis to roll out the new policy for managing medicines in March 2005, synchronising its issue to each ward and (relevant) department with the training of cohorts of staff in the same area. This training was to be completed by the end of August 2005.	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	

Mid Cheshire Hospitals NHS Trust Inquiry					
			• The trust said that changes to the policy for managing medicines will bring the controls assurance score above the minimum 75%. • The trust reported that instances of medicines being left on lockers have fallen since nurses/technicians started wearing red aprons on medicine rounds. The Action Plan (as at 8 March 2006) also listed actions for completion in 2006 which include: establishing and maintaining training programmes; and maintaining audit of attendance to identify significant absences by any level of groups. See "Key Recommendation 9" in the Action Plan for full details.		
	2.4	**24 January 2006:** Procedures must be tightened in respect of the prescription of oxygen.	The Action Plan (as at 8 March 2006) listed actions for completion in 2006 which included: preparing a prescription of oxygen policy; circulating it and arranging related training; and auditing compliance with it. See "Key Recommendation 10" in the Action Plan for full details.	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	
Dealing with allegations against staff					
Improving the ability to raise complaints and concerns	**3.1**	**24 January 2006:** The trust must introduce a clear procedure for investigating serious allegations made against staff and for referring matters to other relevant agencies, including the police. The Healthcare Commission commends this recommendation to all NHS trusts.	The Action Plan (as at 8 March 2006) listed actions for completion in 2005 and 2006 which included: reviewing related policies and procedures; disseminating them widely to all staff groups; and establishing related training programme.	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	

Mid Cheshire Hospitals NHS Trust Inquiry					
			See “Key Recommendation 11” in the Action Plan.		
	3.2	**24 January 2006:** Executive management must be informed of allegations and, if appropriate, involved from the earliest stage.	The Inquiry Report noted that the personnel manager had asked those named in the policy on whistle-blowing to provide details of any approaches from staff. The trust is proposing to amend the policy to reflect this and the need to include a regular report on whistle-blowing to the joint consultation and negotiation committee, HR committee and the board. The Action Plan (as at 8 March 2006) referred to the actions for Key Recommendation 11. See “Key Recommendations 11 and 12” in the Action Plan for full details.	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	
	3.3	**24 January 2006:** The trust must retain an adequate contemporary record of the steps and decisions it has taken for all investigations, including those involved in grievance or disciplinary procedures.	The Action Plan (as at 8 March 2006) listed actions for completion in 2006 which included: ensuring that relevant parts of revised Reporting of Serious Incidents Procedures are incorporated into revised Disciplinary and Grievance Procedures, and supported by templates; and reviewing related policies and procedures. See “Key Recommendation 13” in the Action Plan for full details.	Mid Cheshire report 2 (2006) Action_plan_for_Mid_Cheshire_Hospitals_NHS_trust_Healthcare_Commission_Investigation (2006)	
Managing risk and learning from complaints					
	4.1	**24 January 2006:** The trust must further improve the arrangements to manage risk, ensuring that:	The Inquiry Report noted that the trust reported that a new software system would enable results from Essence of	Mid Cheshire report 2 (2006)	

Mid Cheshire Hospitals NHS Trust Inquiry					
		• the board plays a stronger role in testing and, if necessary, challenging assessments made by trust managers; • the structure and accountability for the management of risk are clear; • the risk manager is vested with sufficient authority to ensure compliance by all directorates; • the consideration of risk is made an integral part of all major management decisions.	Care audits to be measured more effectively and actions to be more focused. The Action Plan (as at 8 March 2006) also listed actions for completion in 2006 which included: reviewing Trust Risk Management Policy and system; "ensuring Directorate access to central risk register; rolling out programme of corporate and directorate development with Mersey Internal Audit system. See “Key Recommendation 14” in the Action Plan for full details.	Action Plan for the Mid Cheshire Hospitals (2006)	
	4.2	The trust should strengthen its system for reporting incidents in the medical directorate. In particular, it should ensure that there is consistent reporting by staff, subsequent feedback, and that action is taken to improve care.	The Action Plan (as at 8 March 2006) listed actions for completion in 2006 repeated the actions for Key Recommendation 14. See “Key Recommendation 15” in the Action Plan for full details.	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	
	4.3	**24 January 2006:** The trust must improve its systems to ensure that appropriate action is taken in response to complaints. In particular, it should ensure that: • the trust board receives full reports of all independent investigations • action plans are generated in response to serious complaints, and then implemented and monitored	The Inquiry Report noted that a new system for handling complaints was put in place which had the capacity to provide more detail on specific areas of concern to patients and their families. It was intended to facilitate the development of action plans and improve the quarterly complaints report. However, the system had only recently been introduced at the data of the Report (January 2006) and the process was still being refined. The trust also reported that:	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	

Mid Cheshire Hospitals NHS Trust Inquiry					
		• the complaints manager is vested with sufficient authority to ensure • compliance by all directorates • learning is disseminated across the trust	• the managers of directorates were now being sent details of clinical complaints or legal claims; • responses from the chief executive to complainants had been copied to the managers of directorates since July 2005; • the medical director now meets with the patient services manager fortnightly to discuss issues arising from complaints and reviews of reports from the Health Service Ombudsman; • issues arising from complaints are being taken to the matrons' patient experience group; • it has developed feedback forms for inclusion in reports to the board on actions taken and lessons learnt. The Action Plan (as at 8 March 2006) also listed actions for completion in 2006 which included: including complaint feedback in Board performance report; advising Board of IRP's; reporting all action deriving from patient surveys into performance report; developing protocols and guidance for Directorates around Patient Services; and developing patient experience group. See "Key Recommendation 16" in the Action Plan for full details.		
	4.4	**24 January 2006:** Managers in the medical directorate must take action to reduce risk and learn from complaints.	The Action Plan (as at 8 March 2006) listed actions for completion in 2006 which included: Medical Directorate and Clinical Governance Committee to identify the overall	Mid Cheshire report 2 (2006)	

Mid Cheshire Hospitals NHS Trust Inquiry					
			themes of complaints, lessons learnt and actions taken to be reviewed; developing protocols to manage the systems and process to manage complaints and risk; Medical Directorate and Patient Safety Group to identify overall themes of risks, lessons learnt and actions taken to be reviewed and monitored; and introducing audit programme. See "Key Recommendation 17" in the Action Plan for full details.	Action Plan for the Mid Cheshire Hospitals (2006)	
Strengthening the HR function					
Regulation and oversight of NHS managers	**5.1**	**24 January 2006:** There must be adequate HR support for ward managers and other middle managers, and consideration should be given to the provision of dedicated specialist support for each directorate.	The Inquiry Report noted that: • Training on equal opportunities would be enhanced by e-learning training packages being introduced in 2005. • The HR committee agreed mandatory training in leadership for all new managers, and established a new leadership group that has been working to develop a leadership framework. The Action Plan referred to the actions at Urgent Action 2. See "Key Recommendation 18 and Urgent Action 2" in the Action Plan.	Mid Cheshire report 2 (2006) Action_plan_for_Mid_Cheshire_Hospitals_NHS_trust_Healthcare_Commission_Investigation (2006)	
	5.2	**24 January 2006:** Those responsible for staffing on the wards need regular, reliable information on staffing including actual staffing levels, vacancies, sickness and turnover. They also require adequate support to use this information effectively.	The Action Plan (as at 8 March 2006) noted an action to establish relevant and timely Trust-wide and Directorate HR information report.	Mid Cheshire report 2 (2006)	

Mid Cheshire Hospitals NHS Trust Inquiry					
			See “Key Recommendation 19” in the Action Plan for full details.	Action Plan for the Mid Cheshire Hospitals (2006)	
Recommendations for the wider health community					
	6.1	**24 January 2006:** The local health community must work together to improve the quality of inpatient care for older patients with medical problems.	The Inquiry Report noted that the trust had recently begun work with the public health department of the primary care trust in looking at the high rates of mortality to ascertain the extent to which they may be problems of coding. Depending on findings, immediate action would be taken with relevant clinicians.	Mid Cheshire report 2 (2006) Action Plan for the Mid Cheshire Hospitals (2006)	
	6.2	**24 January 2006:** The PCT needs to improve the monitoring of the quality of services that it commissions at the trust.	Not known.	No publicly available sources identified to confirm this.	Not known.
	6.3	**24 January 2006:** The strategic health authority needs to have an effective means of testing the accuracy of reports from the trust on progress in clinical governance and the quality of care. This should start with detailed, on site scrutiny of the actions taken by the trust to implement the recommendations of this report.	Not known.	No publicly available sources identified to confirm this.	Not known.

13 LEEDS TEACHING HOSPITALS INQUIRY

13.1 Introduction

On 4 March 2008, staff nurse Colin Norris was convicted of the murder of four patients and the attempted murder of a fifth in 2002 at Leeds Teaching Hospitals NHS Trust and received a prison sentence of a minimum term of thirty years. During a period of six months from May until the 20th of November 2002, five elderly female patients who were all non-diabetic and had undergone surgery to repair a hip fracture, suddenly suffered severe hypoglycaemia resulting in brain damage being either the cause of their deaths or a significant contribution to their deaths.

An independent inquiry was commissioned by Yorkshire and the Humber Strategic Health Authority in August 2008 and the families of Norris's victims were consulted about its terms of reference. The report was based on evidence gathered up to December 2008 and therefore did not take into account developments since that time. The publication of the report was stated to have been delayed for legal reasons, but it was ultimately published on 26 January 2010. The report can be viewed online.

13.2 Leeds Teaching Hospitals Inquiry: Table of Recommendations

Leeds Teaching Hospitals Inquiry (Colin Norris)					
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
National					
	1	**26 January 2010:** The Department of Health should work with the Nursing and Midwifery Council and Council of Deans and Heads of UK University Faculties for Nursing and Health Professions to establish a national reference template to be completed by Universities which identifies the clinical and theoretical performance as well as personality and integrity of a student nurse during the period of their training.	An Action Plan was put in place in January 2010 which stated that it identifies what will be done in response to the inquiry recommendations, at a national level, by the Strategic Health Authority at a regional level, and by the Trust, with the support of NHS Leeds (the "**Action Plan**"). It stated that it would be robustly monitored on a quarterly basis by the Strategic Health Authority Independent Investigations Committee. The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Discussions with NHS Chief Nursing Officer) for England and NHS Medical Director - August and December 2009. 2. With the support of the Chief Nursing Officer, the Strategic Health Authority Director of Patient Care and Partnerships has requested the Council of Deans to work on a 'passport to practice' which is being progressed. The Action Plan also noted the following further actions to be taken:	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.) NHS Employees - NHS Digital Staff Passport Primary Care Passport - Greater Manchester Primary Care	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			1. Monitor progress on production and implementation of the passport to practice. 2. Meetings planned with other UK Chief Nursing Officers to address implementation of passport to practice. In terms of "passports to practice" for nurses, we have identified some evidence of these being used currently on a local level, but not on a national level. For example, in Greater Manchester, nurses working in primary care can obtain passports which keep digital records of the workforce training they have completed. The NHS Digital Staff Passport is a new service which had a 'soft launch' in August 2023 and is currently being piloted with a limited number of NHS trusts. It is currently available to temporary movers and postgraduate doctors in training and enables NHS employees to use their smart phone to share employment, education and training, and occupational health details with NHS trusts 24/7, to support moves between those trusts.		
	2	**26 January 2010:** The Department of Health should work with Deaneries to strengthen the training of junior doctors with respect to: • Certification of death. •The importance of managing risk and the associated processes as a key facet of clinical practice.	The Action Plan noted that the following action had been taken as at 8 January 2010: Discussions with NHS Chief Nursing Officer and NHS Medical Director - August and December 2009 The Action Plan also noted the following further actions to be taken:	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			1. Address the national meeting of Strategic Health Authority Medical Directors for information and action 2. Refer the issues to the national meeting Postgraduate Medical Deans for action 3. Refer the issues to 'Medical Education England' for action 4. Request the Department of Health to document a detailed action plan to coordinate all follow-up work	Incidents (2010) (see page 79 et seq.)	
Yorkshire and the Humber Strategic Health Authority **The Health Authority should:**					
	3	**26 January 2010:** Review the training of junior doctors to improve their knowledge and understanding of certification of death and equip them to understand the importance of managing risk and the associated processes as a key facet of clinical practice.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1.Meetings with Postgraduate Medical Dean 2. Post Graduate Dean and GP Dean attended 'extreme SUI' regional workshop in December 2009 which covered key issues to address The Action Plan also noted the following further actions to be taken: 1. Review current curriculum 2. Identify best practice	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.) NHS Yorkshire and the Humber, Board	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			3. Restructure curricula as necessary 4. Audit junior doctors' understanding of the process as revised across the region The Board Minutes of the meeting of Yorkshire and the Humber Strategic Health Authority held on Tuesday 26 January 2010 (the "**Board Minutes**") noted that, in relation to the issue of interaction between medical and nursing students and the Coroner's office, trainees were now required to follow a process, which included consultation with a senior colleague, documentation and follow-up in team review meetings. The issues identified in this case would be fed into joint working between the NHS in Yorkshire and the Humber and the Home Office, linked to national coronial reforms.	Minutes (Archived, 2010)	
	4	**26 January 2010:** Use the contracting process to address the issue of Universities providing information to NHS organisations about NHS sponsored staff non attendance at courses.	The Action Plan noted that the following actions had been taken as at 8 January 2010: Issue raised and discussed at 'extreme SUI' regional workshop held in December 2009 for medical and nursing directors The Action Plan also noted the following further actions to be taken: 1. Identify key contracts for revision 2. Ensure discussions introduced into monitoring meetings	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			3. Develop protocol for implementation into new contracts 4. Contact workforce development managers in all Trusts and primary care trusts to ensure appropriate action in place to monitor staff at local level		
Leeds Teaching Hospitals NHS Trust Governance **The Trust should:**					
Improving NHS culture and governance	**5**	**26 January 2010:** Embed the new approach to governance across the Trust, ensuring that this is effective in meeting the needs of both the Trust as a whole and individual clinical area such as the orthogeriatric service	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Clinical governance framework produced and approved by Trust Clinical Governance Steering Group, June 2009 2. Terms of Reference for divisional clinical governance forums agreed; systematic approach to clinical governance reviews agreed at Trust Clinical Governance Steering Group, July 2009 3. Implemented clinical governance framework through divisional management structure, July2009 4. Established clinical governance forums in divisions and directorates, September 2009 5. Included clinical governance indicators in divisional performance review process, led by Executive Directors, October 2009	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.) NHS Yorkshire and the Humber, Board Minutes (Archived, 2010)	.

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			6. Patient Safety Walk Rounds established in September 2008; specific walk round on orthopaedic wards January 2010 showed improvements in patient care The Action Plan noted that no further action was to be taken. The Board Minutes noted: (i) that since the inquiry report was finalised (in 2008), a Board-level Clinical Governance Committee had been established by the Trust, including Non-executive membership, which would focus on the issues identified in the report and oversee implementation of actions required by the Trust; and (ii) that there would be very Active Management of the action plan, including monthly management review, quarterly reporting to the Clinical Governance Committee and regular reporting to the Trust Board. The Board Minutes also noted that a Board Member had questioned why some of the actions had yet to be implemented when the incidents had taken place in 2002. In response, it was explained that a number of actions had been taken in the immediate aftermath of the incidents and actions had continued to be undertaken throughout the intervening period. The recommendations in the report reflected current best practice and so had identified some areas where further improvement was necessary.		
Improving patient safety	**6**	**26 January 2010:** Develop and actively use consistent Trust-wide evidence-based measures of the quality and safety of patient care, focussing specifically on the Releasing Time to Care and	The Action Plan noted that the following actions had been taken as at 8 January 2010:	Report of the Independent Inquiry into the	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
		patient safety programmes that are being implemented throughout the Trust	1. Nursing Strategy published 2008/09, including measurement of outcomes 2. Releasing Time to Care (RTC) programme agreed across the Trust 3. Metrics reviewed through Trust patient safety programme 4. Trust subscribed to Association of UK University Hospitals (AUKUH) establishment review tool, benchmarking nurse specific indicators The Action Plan also noted the following further action to be taken: Roll-out Releasing Time to Care programme to all ward areas in the Trust in line with agreed plan,	Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	
Improving NHS culture and governance	**7**	**26 January 2010:** Review the effectiveness of the Trust's assurance framework and other mechanisms for the Board to evaluate Trust performance in relation to clinical quality.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Trust Assurance Framework approved by the Board and Audit Committee, 2008/9 2. Process reviewed by Strategic Health Authority Corporate Governance Lead, November 2008	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			3. Workshop discussion group held with Executive Directors (EDs) and Divisional General Managers (DGMs) to discuss risk and assurance, May 2009 4. Specific Assurance Framework developed for Healthcare Associated Infections (HCAI); Fractured neck of femur review meetings established August 2009, showing improvements in time from admission to surgery 5. Assurance re specific clinical risks addressed at Trust Clinical Governance Steering Group 6. Follow up workshop on Assurance Framework held with Executive Directors and Divisional General Managers, September 2009 7. Clinical Governance Committee Terms of Reference agreed; first meeting October 2009 The Action Plan also noted the following further actions to be taken: 1. Board Assurance Framework to be revised and updated and reviewed at the Trust's Audit Committee and Clinical Governance Committee 2. Trust meeting structure below formal subcommittees of the Trust Board to be reviewed to confirm where assurance is provided	(see page 79 et seq.)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
Improving NHS culture and governance	**8**	**26 January 2010:** Address the gap between the development of policies and their implementation, ensuring that policies are regularly reviewed and that they are audited to check that they are working in practice.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Policy on policies revised and approved 2008, providing guidance to staff 2. Process for the dissemination of policies directly to divisional management teams after approval reviewed and agreed by medical and nursing directorates 3. Review of governance policies undertaken in advance of NHS Litigation Authority assessment, Nov 2009 The Action Plan also noted the following further actions to be taken: 1. Agree plan for auditing of policies in January 2010, to ensure these are embedded in the organisation leading to achieving Clinical Negligence Scheme for Trusts level 2, including auditing of policies from May 2010 2. Use staff survey to review this in future The Board Minutes noted there were ongoing challenges arising from these incidents, including issues relating to the culture and values of the organisation, the consistent application of policies and increasing the prominence of clinical governance within the organisation.	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.) NHS Yorkshire and the Humber, Board Minutes (Archived, 2010)	
	9	**26 January 2010:** Establish an effective, standardised system of audit where directorates feed into a coherent Trust audit programme,	The Action Plan noted that the following actions had been taken as at 8 January 2010:	Report of the Independent Inquiry into the	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
		resulting in consistent collection of information, action in response to recommendations and assurance mechanisms. The audit programme should include a specific audit of clinical records to assure the Board that the quality of record keeping meets clinical and legal requirements.	1. Annual Clinical Audit programme agreed by Trust Clinical Governance Committee March 2009 2. Clinical Audit policy approved March 2009 3. Implemented clinical audit programme through divisional management structure 4. Provided training, advice and support to directorate management teams to ensure effective implementation 5. Undertook an audit of clinical records across all specialties; implement as part of clinical audit programme through divisional management structure, September 2009, outcomes fed back to divisions where improvements need to be made The Action Plan noted that no further action was to be taken.	Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	
Regulation and oversight of NHS managers	**10**	**26 January 2010:** Review how the central risk team is formally coordinated with and supports the devolved directorate structures as the team has a wealth of experience and knowledge that could be used more effectively.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Risk Management Policy revised and approved Sept 2009, including how support is provided to clinicians and managers by Risk Management Team 2. Approach to management of risk reviewed with Executive Directors and Divisional General Managers at workshop discussion group, May 2009	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			3. Risk workshop and training programme provided for directorates 4. Intranet site developed with resources to support operational staff 5. Risk management team engaged with directorates through training events and policy launch The Action Plan also noted the following further action to be taken: E-learning risk and safety training to be launched January 2010 to be completed by all staff working in the Trust and monitored through Clinical Governance Steering Group	(see page 79 et seq.)	
Improving the ability to raise complaints and concerns	**11**	**26 January 2010:** Ensure the timely input of incident data onto Datix and the sharing of lessons learned.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Reviewed process for identifying and sharing lessons learned across the organisation, September 09 2. Lessons learned published in quarterly Bulletin; weekly Healthcare Associated Infections lessons learned from Root Cause Analysis published on intranet 3. Reviewed data inputting process in line with revised incident reporting; timeliness of reporting included in directorate performance review The Action Plan also noted the following further actions to be taken:	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			1. Further improve timeliness of incident data inputting by directorates through education and performance monitoring 2. Develop business case for live web-based incident reporting system 3. Review impact of Lessons Learned publications and other methods of sharing lessons from incidents; proposed to Audit Committee		
Improving patient safety	**12**	**26 January 2010:** Review and update as necessary the Trust policy on safeguarding vulnerable adults in the light of the latest guidance following the "No Secrets" consultation process.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. No Secrets consultation has been reviewed following publication in July 2009 2. Processes put in place for the review of vulnerable adults, led by Deputy Chief Nurse and Nurse Consultant for safeguarding adults, including staff training 3. Completed safeguarding adults policy and procedures review, included guidance from "No Secrets" consultation process, Sept 09 4. Reviewed guidance from Care Quality Commission re compliance with the Health and Social care Act 2008 (Registration Requirements) Regulations 2009; Regulation 9(safeguarding) – agreed evidence required to support application for Registration, Dec 09	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			The Action Plan also noted the following further actions to be taken: 1. Audit of adult safeguarding procedures 2. Compliance statement and evidence Care Quality Commission registration requirement Outcome 7 (safeguarding) to be submitted to the Care Quality Commission 3. Active engagement with clinicians, notably medical staff on adult safeguarding, to embed safeguarding principles in practice as a top priority – through the Clinical Managers Forum and their Development Programme 4. Continue to play an active role in Leeds Adult Safeguarding Board and seek external assurance from the Chair of this Board		

Leeds Teaching Hospitals Inquiry (Colin Norris)					
Improving NHS culture and governance	**13**	**26 January 2010:** Actively promote the new whistleblowing policy through communication and training, thus supporting development of a culture of openness.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Open staff forums established by Chief Executive; opportunities for staff to engage directly with Exec team on issues of concern 2. Patient safety walk round programme established September 2008 3. Patient Care and Safety Days established for nursing staff, including opportunity to raise specific concerns with Chief Nurse	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
Improving the ability to raise complaints and concerns			4. Participated in National Patient Safety Alerts "Being Open" consultation and policy development, October 2009 5. September 2009 – national patient safety week, including benefits of open reporting, strongly promoted by Trust management The Action Plan also noted the following further actions to be taken: 1. Complete review of Trust whistle blowing policy and related policies 2. Communicate policy requirements through directorate HR Managers and staff briefings 3. Audit to check compliance with revised whistle blowing policy and related policies 4. Review staff survey results to further assess staff attitudes to organisational culture and undertake any necessary follow-up work with staff on.		
HR, training and clinical practice issues					
	14	**26 January 2010:** Establish a process for auditing personnel files in order to ensure that (a) the Trust's recruitment processes are complied with; (b) the performance of staff is effectively assessed through	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Divisional management structure implemented May 2008; divisional HR Managers appointed to provide specific support to divisions and directorates, including recruitment	Report of the Independent Inquiry into the Colin Norris Incidents (2002)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
		appraisal; and (c) individual and collective training needs are identified from the appraisal process.	processes and ensuring audit is undertaken and staff receive appraisals 2. Recruitment audit undertaken December 2008 3. Revised appraisal guidance and training 4. Included personal file audit in recruitment policy The Action Plan also noted the following further action to be taken: Undertake further audit of personal files and include in regular audit programme.	Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	
	15	**26 January 2010:** Develop a coordinated education and training programme for staff to respond to the training needs identified through staff appraisal and the development of clinical supervision.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Corporate training needs analysis for mandatory training undertaken. For example, Junior Doctor induction programme established; responded to training needs through delivering prescribing and asepsis training 2. Additional (non-mandatory) training needs identified through annual appraisal process The Action Plan also noted the following further actions to be taken: 1.Undertake a review of mandatory and nonmandatory training needs analysis, corporate training programmes (availability and effectiveness)	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			2.Clinical supervision – see recommendation no.17		
	16	**26 January 2010:** Establish effective workforce information e.g. on establishments, vacancies, sickness and absence levels and actively use this to support management at both Trust and Divisional level.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Performance management information reviewed to include Trust nursing workforce information, July 2009 2. Workforce information available to the Board and divisions 3. Reviewed information that is available to Board and divisions; Nursing workforce information available by directorate for performance management purposes The Action Plan noted that no further action was to be taken.	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	
	17	**26 January 2010:** Review the effectiveness of the current model for the supervision of nursing and other clinical staff.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Review of clinical supervision arrangements completed December 2009 2. Education and training requirements incorporated into Knowledge and Skills Framework (KSF) The Action Plan also noted the following further action to be taken:	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			Agree actions arising from review of clinical supervision arrangements for clinical staff	(see page 79 et seq.)	
	18	**26 January 2010:** Introduce a policy and standards for multidisciplinary working throughout the Trust and to audit practice against these.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Multidisciplinary approach to care established in clinical teams, notably in orthogeriatrics (fully embedded) 2. Established fortnightly corporate medical and nursing directorate meetings in September 09 to review key priority areas to address and promote culture of multidisciplinary working 3. Multidisciplinary team implications and requirements are described in clinical policies when developed or reviewed 4. Standard for multidisciplinary working included in policy guidance The Action Plan also noted the following further action to be taken: Local audit of multidisciplinary care pathways to be included in directorate annual audit plan – to be reported to the Clinical Governance Steering Group	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	
Improving patient safety	**19**	**26 January 2010:** Raise awareness as part of patient safety training amongst staff of the potential	The Action Plan noted that the following action had been taken as at 8 January 2010:	Report of the Independent Inquiry into the	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
		for malicious action against patients by healthcare professionals.	Awareness raised through divisional management structure; corporate medical and nursing directorate; Patient Care and Safety Days; Clinical Managers' meeting. The Action Plan noted that no further action was to be taken. The Board Minutes noted that that Trust Board Members and directors were actively encouraged to carry out patient safety walkabouts throughout the hospital to enable them to track expectations with regard to patient safety and best practice at ward level.	Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.) NHS Yorkshire and the Humber, Board Minutes (Archived, 2010)	
Certification of Death					
	20	**26 January 2010:** Review the internal processes and practices for certification of death in line with best practice with reference to the Pathfinder Pilot established at the Sheffield Teaching Hospitals NHS Foundation Trust.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Reviewed benefits re Sheffield Teaching Hospitals NHS Foundation Trust Pathfinder Pilot 2. Process for Mortality and Morbidity (M&M) reviews included in revised policy, approved August 2009 3. Process in place for consultant medical review of death certification in elderly medicine	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			4. Alert sent out to all areas describing actions to take in the event of unexpected hypoglycaemia 5. Reviewed process for death certification within the Trust, November 2009; implemented Dec 09 6. Introduced process for checking of death certification, issued guidance to clinical teams through divisional structure, November 2009 The Action Plan also noted the following further action to be taken: Audit of revised process for death certification	(see page 79 et seq.)	
Medicines Management					
Improving patient safety	**21**	**26 January 2010:** Review the terms of reference for the Medicines Risk Management Sub Committee, including membership and accountability/reporting arrangements within the Trust's overall governance structure.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. External review of Trust committee structure, by Capita, commissioned in 2008/09, review completed 2. Board time-out to consider recommendations took place in May 2009 3. Reviewed Trust Drugs & Therapeutics Committee and the Risk Management sub-committee membership and Terms of Reference	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	.

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			The Action Plan noted that no further action was to be taken.		
	22	**26 January 2010:** Complete outstanding documents relating to pain management guidance, in particular the assessment and management of irregular pain.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Trust pain guidelines review completed 2. Guidelines published on Leeds Health Pathways site, May 2009 The Action Plan noted that no further action was to be taken.	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	
Improving patient safety	23	**26 January 2010:** Review the pharmacy procedure titled 'Scheduled visits by pharmacists to wards' and the "Policy on Clinical Pharmacy Practice" and incorporate the role of the visiting pharmacist and monitoring of compliance with the Trust Medicines Code as a key component of the visit.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. All Pharmacy standard operating procedures (including the policy on clinical pharmacy practice') have been reviewed and updated where required 2. The specific document "Scheduled visits by pharmacists to wards" has been completed and relaunched, September 2009 3. Trust Medicine's Code web based site developed and launched to improve immediate Trust wide access to reference material that can be updated regularly	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			4. Daily audit of prescribing standards in place, specific focus in national patient safety awareness week on prescribing, September 2009 5. Improving prescribing standards work programme agreed, September 2009 The Action Plan also noted the following further action to be taken: Undertake specific audit of compliance with relaunched procedures on 'Scheduled visits by pharmacists to wards' and 'policy on clinical pharmacy practice'		
	24	**26 January 2010:** Review clinical pharmacy support to the wards and ensure that provision is sufficient to meet ward needs	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Ward-based pharmacy provision reviewed and new model in place 2. Undertaken review of clinical pharmacy support to the wards; skill-mix and rotational arrangements for ward-based pharmacists have been reviewed to improve pharmacy support to wards, such that ward-based pharmacy support is sufficient to meet ward needs The Action Plan noted that no further action was to be taken.	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	
Improving patient safety	**25**	**26 January 2010:** Place a higher priority on the implementation of technological solutions to	The Action Plan noted that the following actions had been taken as at 8 January 2010:	Report of the Independent Inquiry into the	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
		improve the audit trail of drug use and reduce patient risk. This should include: • Automated dispensing system for access of drugs from the out of hours drug cupboard (this should also be considered for the A&E department) • Automated dispensing in pharmacy • Swipe card technology for access to drug cupboards instead of keys • Electronic prescribing and administration of drugs.	1. Review of technological solutions has been undertaken 2. Electronic prescribing established for chemotherapy in adults and children. 3. One automated pre-labelled pre-packaged medicines robot established at St James's University Hospitals NHS Trust Minor Injuries Unit 4. Robotic dispensing in pharmacy established in Chancellor and Bexley Wing, Chapel Allerton and being installed in Gledhow Wing, St James's University Hospitals NHS Trust, 5. Replacement and additional lockable medicines storage in ward areas 6. Interim out of hours drug storage processes reviewed; individual staff identity required to access out of hours drugs, security staff control access; security protected in line with peer organisations The Action Plan also noted the following further actions to be taken: 1. Implement the initial phases of an e-prescribing and medicines administration system to determine feasibility of full implementation 2. Further business case for automation in pharmacy at Leeds General Infirmary	Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			3. Implementation of Leeds General Infirmary pharmacy automation 4. Implementation of automated out of hours medicines storage		
Improving patient safety	**26**	**26 January 2010:** Undertake an audit of the omission of administration of drugs prescribed including the reasons why the drug has been omitted, what nursing staff involved have done to obtain the drugs required and who authorised the non-administration.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Audit of missed doses undertaken September 2009 2. Prescription chart checking included in patient safety walk round programme, September 2009 3. New prescription stationery introduced, process for recording omission of medicines has been reviewed and a new system implemented The Action Plan noted that no further action was to be taken. The Board Minutes also noted that an audit of records had been conducted in all specialties in 2009. Protocols prevented agency nursing staff from having seniority on any shift and from administering drugs.	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.) NHS Yorkshire and the Humber, Board Minutes (Archived, 2010)	
	27	**26 January 2010:** Ensure that controlled drug audits are up-to-date with copies of completed audit reports provided to the Medicines Risk Management Sub Committee as part of the Accountable Officer's report. Where it is not possible to undertake these audits due to difficulties	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Controlled drugs checking procedures reviewed and updated in line with legislation i.e. checks at ward level	Report of the Independent Inquiry into the Colin Norris Incidents (2002)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
		in recruiting staff, the associated risk needs to be recorded on the Trust risk register. The three monthly audit of controlled drug records should include an audit of compliance of the receipt section of the controlled drug order book bearing a signature to verify receipt has occurred and by whom.	undertaken daily; 100% compliance achieved at last audit in September 2009. 2. Quarterly review of controlled drugs checks reported to medicines management assurance meeting. 3. 2008 Annual Accountable Officer report reviewed at the Trust Drugs & Therapeutics Risk Management sub committee, October 2009 4. Risk Register reviewed, November 2009 5. Pharmacy technician role redesigned to enable a broader skill mix to undertake controlled drugs quarterly checks. 6. Controlled drugs audits undertaken and include signing receipt section of the controlled drugs order book 7. Audit results fed into directorate management team for monitoring and action where required The Action Plan noted that no further action was to be taken.	Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
Improving patient safety **Improving NHS culture and governance**	**28**	**26 January 2010:** Raise the profile of the need to sign the receipt section of the controlled drug order book possibly by emphasising this as part of the three monthly audit of controlled drug records.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Signing receipt section of the controlled drug order book is integrated into 3 monthly audit of controlled drug records 2. Awareness raised with nursing staff through Matron structure and Patient Care & Safety days 3. Integrated into inspection programme as part of the medicines management clinical inspections 4. Audit results fed into directorate management team for monitoring and action where required The Action Plan also noted the following further action to be taken: Continue to undertake 3 monthly audits of Controlled Drug stock in clinical areas; specifically to include a check on receipt section of Controlled Drug order book	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	
Listening to Relatives					
Raising complains and concerns	**29**	**26 January 2010:** Raise awareness of the Trust policy for listening to, formally recording and acting on information and concerns expressed by relatives so that relatives' views may be taken into account in care planning and review.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Process reviewed as part of Trust complaints policy review – see recommendation 31	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			2. Patient Care & Safety Days established in 2009; forum used to raise awareness of recording concerns expressed by relatives 3. Nursing & Midwifery Strategy 2008/09 published, focussing on involving patient and carers 4. Carers Charter published 2009 5. Trust complaints policy communicated to all nursing and clinical staff through Patient Care & Safety Days and established communication routes to all staff groups 6. LINk (Local Involvement Network) established to work in partnership with the Trust on behalf of patients and carers The Action Plan noted that no further action was to be taken.	Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	
	30	**26 January 2010:** Undertake further work to clarify the roles of and communication between Matrons and the Patient and Public Liaison Service (PALS).	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Trust complaints process revised April 2009 in line with the new national reforms and guidance, making explicit the role of divisional and directorate management teams, including Matrons; Patient Care and Safety Days established fortnightly, addressed communication skills through this 2. Reviewed Trust complaints policy, to include role of Patient Advice Liaison Service (PALS)	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			3. Nursing & Midwifery Strategy 2008/09 published, focus on achieving effective communication with patients to provide high quality care 4. Completed the implementation of new complaints process through divisions; monitored through divisional performance management process The Action Plan noted that no further action was to be taken.	(see page 79 et seq.)	
Improving the ability to raise complaints and concerns	**31**	**26 January 2010:** Review complaints handling to ensure that there is sufficient independence in investigations and that action is taken in response to issues raised.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Trust complaints process reviewed and revised April 2009 in line with the new national policy and guidance, making explicit the role of divisional and directorate management teams 2. Complaint investigations led by Matrons not involved in direct care of the patient involved, action plans and responses signed off by Divisional General Managers 3. Patient Relations Team and Directorates review actions that have been taken to deal with issues raised in complaints and identify learning, recording this in quarterly complaints report 4. Monitored through divisional performance management process and Trust Risk Assessment Committee	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			The Action Plan also noted the following further action to be taken: Establish mechanisms for feedback from complaints to directorates, local management teams and staff to inform quality improvements		
Improving the ability to raise complaints and concerns	**32**	**26 January 2010:** Should audit compliance with the Trust's serious untoward incident policy to ensure that following incidents, there is effective communication with and support to patients, their relatives and staff.	The Action Plan noted that the following actions had been taken as at 8 January 2010: 1. Serious untoward incident policy revised and approved by Senior Management Team (SMT), December 2008 2. Trust internal audit department completed review of compliance with serious untoward incident process, August 2009 3. Deputy Risk Manager appointed March 2009 with specific responsibility for monitoring the progress of all SUI investigations to support effective communication to patients, relatives and staff. 4. Serious untoward incident training provided by external management team May 2009, included providing support to patients, relatives and staff 5. Proactive meeting set up with commissioners to agree new process for managing serious untoward incidents 6. Actions reviewed at weekly serious untoward incident and incident review meeting, including discussing specific	Report of the Independent Inquiry into the Colin Norris Incidents (2002) Action Plan - Independent Inquiry into the Colin Norris Incidents (2010) (see page 79 et seq.)	

Leeds Teaching Hospitals Inquiry (Colin Norris)					
			issues re support and communication with patients, relatives and staff 7. Facilitated open meeting for Lead Investigators, December 2009 to review support required to undertake serious untoward incident investigations, including support and communication with patients, relatives and staff 8. Raised awareness of National Patient Safety Alerts Being Open framework issued as an Alert, November 2009 and agreed plan for implementing actions, including training provided for staff The Action Plan also noted the following further actions to be taken: 1. Implement further actions on serious untoward incident policy compliance from Internal Audit Report – report back to Audit Committee 2. Implement National patient Safety Alerts Being Open framework		

14 AIREDALE INQUIRY

14.1 Introduction

In 2003, a night nurse practitioner (NNP) employed by Airedale NHS Trust, Mrs Anne Grigg Booth, was arrested and charged with 3 offences of murder, one of attempted murder and thirteen offences of administering noxious substances with intent to cause grievous bodily harm. The victims of the alleged offences, which took place between 2000 and 2002, were patients at Airedale NHS Trust where Mrs Grigg Booth had worked for over 25 years. In 2005 Mrs Grigg Booth died of an overdose before the charges could be tried in court. In October 2008, the Department of Health confirmed that the Secretary of State for Health should set up an independent inquiry to examine the incidents at Airedale NHS Trust. The inquiry was set up in 2009 and chaired by Kate Thirlwall QC (as she was then). It presented its report on 8 June 2010. The report can be viewed online.

14.2 Airedale Inquiry: Table of Recommendations

Airedale Inquiry					
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
The Trust					
	1	**8 June 2010: Patients and families** The Trust should consider, (in discussion with the Strategic Health Authority) how best to communicate with the patients and families who have been affected by the events we have considered. As a minimum we would expect the Trust to invite those patients and families who wish to do so to meet the current Chief Executive, Medical Director and Director of Nursing.	An Action Plan was presented to the Strategic Health Authority Board on 8 June 2010 which stated that it identifies what will be done in response to the inquiry recommendations, by the Trust, with the support of NHS Bradford and Airedale, and at a regional and national level. It stated that it would be robustly monitored on a quarterly basis by the Strategic Health Authority Independent Investigations Committee. The Action Plan noted that the following actions had been taken as at 31 May 2010: As agreed with the Strategic Health Authority, the Chief Executive, Medical Director and Director of Nursing have drafted a letter to invite patients and families affected by events to meet with them if they wish. Options will be offered ie group meetings or individual meetings, either at the Trust or another venue if so wished. Meetings may include detailed review and discussion of relevant health records if required. This will follow the scheduled meeting between patients and families and a member of the inquiry panel, plus the Strategic Health Authority Director of Patient Care and Partnerships on 7 June 2010.	The Airedale Inquiry Report (2010) Action Plan, Airedale Inquiry (2010)	

Airedale Inquiry					
			If patients and families would prefer a written response to the inquiry findings from the Trust, this will be provided. The Trust has prepared a communications plan to inform the community it serves about the findings of the inquiry and the quality and safety of its services. The plan includes a series of events with the Trust's Council of Governors, Foundation Trust membership and staff groups. The Action Plan did not note any further action to be taken.		
Improving NHS culture and governance	**2**	**8 June 2010: Corporate Governance** The Trust should make time in the Board agenda for periodic reviews of the new corporate governance arrangements to ensure that systems and processes do not take precedence over patients.	The Action Plan noted that the following actions had been taken as at 31 May 2010: Board work plan schedule revised to include a formal annual review of the Board/Committee governance committee structure. The first review was finalised by March 2010 as part of the preparation for Foundation Trust status. It is established process at the end of each Trust Board meeting to hold a review and check that all members were satisfied with the content and conduct of the meeting. The Action Plan also noted the following further action to be taken: Board to undertake formal annual review of Trust governance arrangements.	The Airedale Inquiry Report (2010) Action Plan, Airedale Inquiry (2010)	

Airedale Inquiry					
Regulation and oversight of NHS managers	**3**	**8 June 2010: Corporate management** The Trust Board should demonstrate how it will ensure that the Chief Executive and his team keep the effectiveness of the management structure under review.	The Action Plan noted that the following actions had been taken as at 31 May 2010: Board work plan schedule revised to include a formal annual review of the corporate management structure. Review of Executive portfolios and underpinning management arrangements undertaken March 2010 and considered at Trust Board to ensure effectiveness of management structure. Executive review of Director portfolios as vacancies arise and as business demands change for example, Director of Finance appointment in 2009. Annual Plan and Performance objectives inform objectives of Executive Directors and senior managers. Chief Executive's objectives set in agreement with the Remuneration Committee. The Action Plan also noted the following further actions to be taken: Board to undertake formal annual review of the Trust's governance arrangements including the corporate management structure. A streamlined decision making and accountability structure across the organisation to be introduced.	The Airedale Inquiry Report (2010)	

Airedale Inquiry					
			Further planned reviews of Director portfolios on a quarterly basis and as necessary as vacancies arise and as business demands change. Annual performance review and objective setting for Executive Directors in line with Annual Plan and Performance objectives. On-going annual reviews.		
	4	**8 June 2010: Human Resources** The Trust Board should satisfy itself regularly that: i) staff appraisals and personal development planning are effective. ii) the HR department is sufficiently resourced to deliver the organisational Development Programme.	The Action Plan noted that the following actions had been taken as at 31 May 2010: Quarterly Trust Board monitoring of appraisals against a target of 90% completion rate. As well as achieving the target completion rate, it is recognised that the quality of the HR appraisal experience ie dialogue with the line manager is vital if the process is to positively impact on performance and the individual's development. Recruitment process in place to funded establishment in HR Department. Organisational Development Programme is the collective responsibility of Executive Directors and their teams. The Organisational Development framework is structured to ensure delivery is integral to directors' portfolios and objectives. It is to be delivered by an integrated programme of work - the Quality, Innovation, Productivity and Prevention programme.	The Airedale Inquiry Report (2010) Action Plan, Airedale Inquiry (2010)	

Airedale Inquiry					
			The Action Plan also noted the following further actions to be taken: Recovery plans to be developed for areas not on target for completing appraisals. Quality and effectiveness of appraisal experience to be audited during 2010. Review of the Organisational Development programme biannually as part of the planning and performance cycle.		
Improving patient safety	**5**	**8 June 2010: Training/Induction** The Trust should consider: i) whether or not doctors should be required as part of their practice when examining patients to review the prescription charts as well as the clinical records. **ii)** whether induction courses for junior doctors and nurses are sufficiently explicit about the role and scope of practice of the other professionals.	The Action Plan noted that the following actions had been taken as at 31 May 2010: The Trust is currently considering methodology to enhance the record keeping and audit of doctors' review of prescription charts by utilising the recently revised regional prescription chart. A trial is currently underway to make this a simple and quick process. E-induction programme for junior doctors includes a section entitled 'Role of the Junior Doctor' which states that a good doctor should work well within a team. The programme has been extended to include a section on the roles and scope of other professionals in preparation for the August 2010 intake. Prescribing tutorials are given to FY1 doctors by pharmacists. Training sessions provided on the Trust's Clinical Induction Programme for registered nurses and operating department practitioners are constantly being updated to	The Airedale Inquiry Report (2010) Action Plan, Airedale Inquiry (2010)	

Airedale Inquiry					
			reflect changes in professional legislation and clinical practice. While nurses' roles and responsibilities are explicit, the roles and responsibilities of other healthcare professionals with whom they work are implicit in the induction programme. The programme provides information on professional accountability and the Medicines Code. Records are kept by the Nursing Practice Development Team. There is an established rolling programme of clinical updates, including medicines management and professional accountability that existing nurses attend on an annual basis The Action Plan also noted the following further actions to be taken: Pharmacy to evaluate trial and if effective new process will be developed and implemented. Medical staff to be made aware of policy change through pharmacy and Medical Director Unit alerts. Compliance with the chart will be assessed in the 2010 case note audit. E- induction programme for junior doctors to be added to the Trust electronic learning management system for tracking purposes. The programme will be updated annually. A Trust Intranet site to be developed for junior doctors to access policies and guidelines easily.		

Airedale Inquiry					
			The clinical induction programme will be reviewed in light of the soon to be launched new *Policy for the Administration of Medicines by Nurses, Midwives and Operating Department Practitioners* (and following its ratification via the Trust's processes) and the Trust's Advancing Clinical Practice policy. This will make explicit the roles and responsibilities of other healthcare professionals within the team (and as set out in the above *Medicines* policy). Local induction (at ward/ department level) will be reviewed and will include clear aims and objectives in order to ensure that this induction describes the roles and responsibilities of individuals within the team. Also, local induction will be developed so that it supplements and complements both corporate and clinical induction. Follow up audit of impact.		
National					
Improving patient safety	**6**	**8 June 2010:** When the scope of healthcare professionals' roles are extended to incorporate new responsibilities that impact on patient care eg nurse prescribing, NHS organisations should ensure: i) that clear lines of accountability are in place; ii) that training and development plans are fit for purpose;	The Action Plan noted that the following actions had been taken as at 31 May 2010: Preliminary discussions held with Deputy Chief Nursing Officer for England. Issues discussed at meeting between Chief Nursing Officer (for England and Nurse Directors for all Strategic Health Authorities. The Action Plan also noted the following further actions to be taken:	The Airedale Inquiry Report (2010) Action Plan, Airedale Inquiry (2010)	

Airedale Inquiry					
		iii) that there is appropriate evaluation of the effectiveness of the role within the organisation; and iv) that there is effective dialogue and engagement with patients, carers and the public.	Further action to be identified and agreed at national level. Inquiry report and action plan to be published on Strategic Health Authority website and distributed widely at a regional and national level after 8 June Strategic Health Authority Board meeting; recommendations to be highlighted to relevant audiences, including national Foundation Trust Network. Regional action learning event to identify action in response to recommendations scheduled.		
Improving NHS culture and governance	**7**	**8 June 2010:** Governance systems in NHS provider organisations need to be designed to reflect Boards' 24 hour a day responsibility for all areas of service delivery.	The Action Plan noted that the following action had been taken as at 31 May 2010: Issue discussed at meeting between Chief Nursing Officer for England and Nurse Directors for all Strategic Health Authorities. The Action Plan also noted that further action was to be identified and agreed at national level. Some evidence of the recommendations being discussed at board level in other trusts (e.g. West Hertfordshire Hospitals NHS Trust Board Meeting of 29 July 2010).	The Airedale Inquiry Report (2010) Action Plan, Airedale Inquiry (2010) West Hertfordshire Hospitals NHS Trust Board Meeting of 29 July 2010	
Improving patient safety	**8**	**8 June 2010: Training/Induction** The Department of Health should reflect on the matters raised in paragraph 5 above and consider	The Action Plan noted that the following action had been taken as at 31 May 2010: Preliminary discussions with Deputy Chief Nursing Officer for England.	The Airedale Inquiry Report (2010)	

Airedale Inquiry					
		whether they should be the subject of wider consideration within the NHS.	The Action Plan also noted that further action was to be identified and agreed at national level.	Action Plan, Airedale Inquiry (2010)	
	9	**8 June 2010: Working with the police** The Department of Health should seek information from health care providers about their experiences of working with the police in order to review the effectiveness of the Memorandum of Understanding and the Department's guidance from the perspective of the health care providers. Guidance on the retention, recording and copying of documents and the need for control and access may need to be more detailed and robust.	The Action Plan noted that the following actions had been taken as at 31 May 2010: Discussions with Deputy Chief Nursing Officer re: Department of Health action in response to this issue at national level. At regional level – Strategic Health Authority staff progressing action with West Yorkshire Police and other forces within the Yorkshire and Humber region. At regional level - preliminary discussions held between the Strategic Health Authority and West Yorkshire Police on guidance. The Action Plan also noted the following further actions to be taken: Further action to be identified and agreed at national level. Action to be taken and formally documented to ensure more effective implementation of the Memorandum of Understanding - Strategic Health Authority and West Yorkshire Police - for roll out to other forces and all NHS organisations in Yorkshire and the Humber. Production of guidance in conjunction with NHS organisations and police forces.	The Airedale Inquiry Report (2010) Action Plan, Airedale Inquiry (2010)	

Airedale Inquiry					
	10	**8 June 2010:** The guidance should be developed so that it includes detailed help on the following: • in what circumstances, if ever, should a member of the staff of the hospital being investigated be seconded to work as part of the police team. What considerations should be borne in mind when a request is made from the police for such support? We suggest the following matters ought to be considered: a) why is it necessary to second someone rather than use them as an adviser? b) is the person wholly independent of the matters and people being investigated? c) what is the adviser/secondee permitted to discuss outside the police team? What effect may this have on the adviser/secondee professionally and personally? d) what support is the proposed adviser/secondee to be given? e) how is the adviser's/secondee's role to be explained within the organisation? f) or how long is the secondment to last? Should it be a rotating secondment amongst a group of staff? g) can the work needed by the police be carried out by someone or a team from outside the organisation?	The Action Plan referred to the response to Recommendation 9 (above).	The Airedale Inquiry Report (2010) Action Plan, Airedale Inquiry (2010)	

Airedale Inquiry					
	11	**8 June 2010:** The guidance should also alert organisations to the need to give effective support to those who are giving witness statements (should such support be considered necessary). It may not be appropriate for managers to sit in on such interviews.	The Action Plan noted that the following actions had been taken as at 31 May 2010: Preliminary discussions with Deputy Chief Nursing Officer for England re: Department of Health response to this issue nationally. Materials (ie staff leaflet, policy, guidance for senior managers on staff support) circulated in May 2010 to all Directors of Nursing in Yorkshire and the Humber, the Chief Nursing Officer for England (for onward circulation to Chief Nursing Officers covering Northern Ireland, Scotland and Wales), Strategic Health Authority Nurse Directors throughout England and the Chair of the Foundation Trust Network. The Action Plan did not note any further action to be taken.	The Airedale Inquiry Report (2010) Action Plan, Airedale Inquiry (2010)	

15 INDEPENDENT INQUIRY INTO CARE PROVIDED BY MID STAFFORDSHIRE NHS FOUNDATION TRUST JANUARY 2005 – MARCH 2009

15.1 Introduction

An independent inquiry set up in relation to serious failings in the standard of care at Mid-Staffordshire NHS Foundation Trust between January 2005 and March 2009. The Inquiry was chaired by Sir Robert Francis QC. The report of the Inquiry was delivered in February 2010.

The Inquiry was tasked with:

- Investigating individual cases relating to the care provided by Mid Staffordshire NHS Foundation Trust between 2005 and 2009 that caused it concern.
- In the light of such investigation, considering any additional lessons to be learned beyond those identified by previous investigations carried out into the Trust.
- Considering what additional action was necessary for the new hospital management to ensure the Trust was delivering a sustainably good service to its local population.

The Inquiry identified significant failings in the quality of care provided at the Trust across a number of wards and departments. Patients had been exposed to unnecessary suffering and denial of their dignity. There were basic errors in nursing care. The culture of the Trust was not conducive to providing good care for patients or providing a supportive working environment. There were failures of governance, particularly in relation to the complaints system. Actions taken by management to address issues identified were ineffective. There was a focus on financial pressures and achieving foundation trust status, to the determine of quality of care. The board acted with a lack of urgency in remedying deficiencies.

The Inquiry made 18 recommendations. Each were accepted in full by the Department of Health and the board of Mid Staffordshire NHS Foundation Trust.

15.2 Mid-Staffordshire Independent Inquiry: Table of Recommendations

Mid-Staffordshire Independent Inquiry					
Type of Recommendation	No.	Details of Recommendation	Implementation	Source	Extent of Implementation
Improving patient safety	1	The Trust must make its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard.	In its 2010/11 Controls Assurance Framework Register, the Trust said it was continuing to consider and prepare proposals for the future of clinical services where it was deemed the Trust is unable to achieve a high-class standard of care within current clinical arrangements. Mid Staffordshire NHS Foundation Trust was dissolved in November 2014.	Papers for Mid Staffordshire Trust Board Meeting, 27 January 2011 (nationalarchives.gov.uk)	

Mid-Staffordshire Independent Inquiry					
Improving NHS culture and governance	2	The Secretary of State for Health should consider whether he ought to request that Monitor – under the provisions of the Health Act 2009 – exercise its power of de-authorisation over the Mid Staffordshire NHS Foundation Trust. In the event of his deciding that continuation of foundation trust status is appropriate, the Secretary of State should keep that decision under review.	In his statement to the House of Commons on 24 February 2010, the then Secretary of State for Health said that he accepted this recommendation and would ask Monitor to consider deauthorising the Trust when the powers to do so came into effect. The Secretary of State wrote to Monitor on 24 March 2010, stating he believed de-authorising the Trust was necessary.	Volume 506: debated on Wednesday 24 February 2010 - Hansard - UK Parliament Mid Staffs asks to be stripped of foundation status, Nursing Times, 31 March 2010 | Nursing Times	
Improving NHS culture and governance	3	The Trust, together with the Primary Care Trust, should promote the development of links with other NHS trusts and foundation trusts to enhance its ability to deliver up-to-date and high-class standards of service provision and professional leadership.	In its 2010/11 Controls Assurance Framework Register, the Trust said that it had developed an action plan for increased and improved links with other healthcare providers by building on existing clinical network arrangements. According to the Trust, various actions had been completed as planned included an external review of serious untoward incidents, deanery visits and staff secondments to other trusts.	Papers for Mid Staffordshire Trust Board Meeting, 27 January 2011 (nationalarchives.gov.uk)	

Mid-Staffordshire Independent Inquiry					
Improving NHS culture and governance	4	The Trust, in conjunction with the Royal Colleges, the Deanery and the nursing school at Staffordshire University, should review its training programmes for all staff to ensure that high-quality professional training and development is provided at all levels and that high-quality service is recognised and valued.	In its 2010/11 Controls Assurance Framework Register, the Trust said it had appraised the training programmes for all clinical staff and developed an action plan for areas required improvement, which included taking the outputs of the deanery quality assurance visit. The Trust also said it had developed and implemented a clinical medical leadership and management training needs analysis, and a clinical medical leadership programme for senior medical staff.	Papers for Mid Staffordshire Trust Board Meeting, 27 January 2011 (nationalarchives.gov.uk)	
Improving patient safety	5	The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in audit processes in accordance with contemporary standards of practice a requirement for all relevant staff. The Board should review audit processes and outcomes on a regular basis.	In its 2010/11 Controls Assurance Framework Register, the Trust said it had: • Embedded recently established mechanisms for actions and outcomes of clinical audits, which were to eb reviewed by the Audit Committee and Healthcare Governance Committee on a quarterly basis following monthly review by the Clinical Audit Group. • Examined the arrangements for clinical audit in each directorate to ensure compliance with Trust-wide standards.	Papers for Mid Staffordshire Trust Board Meeting, 27 January 2011 (nationalarchives.gov.uk)	
Improving the ability to raise complaints and concerns	6	The Board should review the Trust's arrangements for the management of complaints and incident reporting in the light of the findings of this report and ensure that it: • provides responses and resolutions to complaints which satisfy complainants;	In its 2010/11 Controls Assurance Framework Register, the Trust said it had: • Completed an evaluation of the management of incidents, with a paper provided to executive directors on audit of incident reporting with	Papers for Mid Staffordshire Trust Board Meeting, 27 January 2011 (nationalarchives.gov.uk)	

Mid-Staffordshire Independent Inquiry					
		• ensures that staff are engaged in the process from the investigation of a complaint or an incident to the implementation of any lessons to be learned; • minimises the risk of deficiencies exposed by the problems recurring; and • makes available full information on the matters reported, and the action to resolve deficiencies, to the Board, the governors and the public	recommendations for further changes being implemented. • Introduced complaints review panels to monitor lessons learnt and specific actions at directorate level. • Amended Board reports so that they provided meaningful information about trends and stories in complaints. • Established a Task and Finish group to work towards the aim of all complaints being addressed within 28 days.		
Improving patient safety	7	Trust policies, procedures and practice regarding professional oversight and discipline should be reviewed in the light of the principles described in this report.	In its 2010/11 Controls Assurance Framework Register, the Trust said it had reviewed all Trust policies and procedures to ensure that they were up to date and did not contain areas of ambiguity or uncertainty. The action taken was said to include a review of all policies required for NHS Litigation Authority and amendment of those policies to bring them up to date. The Trust said that policies would be reviewed on an ongoing basis using a new SharePoint database.	Papers for Mid Staffordshire Trust Board Meeting, 27 January 2011 (nationalarchives.gov.uk)	
Improving the ability to raise complaints and concerns	8	The Board should give priority to ensuring that any member of staff who raises an honestly held concern about the standard or safety of the provision of services to patients is supported and protected from any adverse consequences, and should foster a culture of openness and insight.	In its 2010/11 Controls Assurance Framework Register, the Trust said it had agreed a policy which supported appropriate options for staff to raise concerns without fear of operation. The Trust said this policy had been communicated throughout the organisation.	Papers for Mid Staffordshire Trust Board Meeting, 27 January 2011 (nationalarchives.gov.uk)	

Mid-Staffordshire Independent Inquiry					
Regulation and oversight of NHS managers	9	In the light of the findings of this report, the Secretary of State and Monitor should review the arrangements for the training, appointment, support and accountability of executive and non-executive directors of NHS trusts and NHS foundation trusts, with a view to creating and enforcing uniform professional standards for such posts by means of standards formulated and overseen by an independent body given powers of disciplinary sanction.	In his statement to the House of Commons on 24 February 2010, the then Secretary of State for Health said that he would consult on a new system of professional accreditation for senior NHS managers.	Volume 506: debated on Wednesday 24 February 2010 - Hansard - UK Parliament	
Improving NHS culture and governance	10	The Board should review the management and leadership of the nursing staff to ensure that the principles described in the report are complied with.	In its 2010/11 Controls Assurance Framework Register, the Trust said it had reassessed changes already made in the management and leadership of nursing staff at each level within the Trust. A review of the Practice Development Team was in progress and a second Deputy Director of Nursing Post had been created. The Trust also said it had developed and commenced a nursing leadership and management training needs analysis. An initial assessment had been undertaken, with a detailed assessed to be delivered through the Professional Nursing Group.	Papers for Mid Staffordshire Trust Board Meeting, 27 January 2011 (nationalarchives.gov.uk)	
Improving NHS culture and governance	11	The Board should review the management structure to ensure that clinical staff and their views are fully represented at all levels of the Trust and that they are aware of concerns raised by clinicians on	In its 2010/11 Controls Assurance Framework Register, the Trust said it had enacted and evaluated a new development structure. This had included a review of	Papers for Mid Staffordshire Trust Board Meeting, 27 January 2011	

Mid-Staffordshire Independent Inquiry					
		matters relating to the standard and safety of the service provided to patients	clinical engagement. Further action was being taken through a clinical leadership development programme.	(nationalarchives.gov.uk)	
Improving NHS culture and governance	12	The Trust should review its record-keeping procedures in consultation with the clinical and nursing staff and regularly audit the standards of performance.	In its 2010/11 Controls Assurance Framework Register, the Trust said that quarterly record-keeping audits to be reported to the Health Governance Committee and Audit Committee had been put in place, along with monthly audit meetings. The Trust said that weekly ward audit plans had been monitored with matrons. The Trust further said it had develop a Data Quality Strategy and Plan to incorporate all aspects of clinical record keeping.	Papers for Mid Staffordshire Trust Board Meeting, 27 January 2011 (nationalarchives.gov.uk)	
Improving patient safety	13	All wards admitting elderly, acutely ill patients in significant numbers should have multidisciplinary meetings, with consultant medical input, on a weekly basis. The level of specialist elderly care medical input should also be reviewed, and all nursing staff (including healthcare assistants) should have training in the diagnosis and management of acute confusion.	In its 2010/11 Controls Assurance Framework Register, the Trust said that: • It had produced a plan, via induction and Staffordshire University courses, for ensuring all nursing staff had training in diagnosis and management of acute confusion. • All nursing and health care support worker staff were undergoing training in the management of acutely confused patients or those diagnosed with dementia. • Consultant-led multidisciplinary meetings across elderly and acutely ill wards had been put in place. • It would revise the pathway of care for elderly patients.	Papers for Mid Staffordshire Trust Board Meeting, 27 January 2011 (nationalarchives.gov.uk)	

Mid-Staffordshire Independent Inquiry					
Improving patient safety	14	The Trust should ensure that its nurses work to a published set of principles, focusing on safe patient care.	In its 2010/11 Controls Assurance Framework Register, the Trust said that Trust-wide values and behaviours were being used for nurses and were supplemented through the establishment of nursing indicators and comfort check standards.	Papers for Mid Staffordshire Trust Board Meeting, 27 January 2011 (nationalarchives.gov.uk)	
Improving patient safety	15	In view of the uncertainties surrounding the use of comparative mortality statistics in assessing hospital performance and the understanding of the term 'excess' deaths, an independent working group should be set up by the Department of Health to examine and report on the methodologies in use. It should make recommendations as to how such mortality statistics should be collected, analysed and published, both to promote public confidence and understanding of the process, and to assist hospitals to use such statistics as a prompt to examine particular areas of patient care.	In his statement to the House of Commons on 24 February 2010, the then Secretary of State for Health said that he accepted this recommendation. The Secretary of State said he would establish an independent working group to examine and report on the methodologies in use. The Report from the Steering Group for the National Review of the Hospital Standardised Mortality Ratio was published in November 2010. It recommended the adoption of a methodology for a national mortality ratio for use across the NHS, to be known as the Summary Hospital-level Mortality Indicator.	Volume 506: debated on Wednesday 24 February 2010 - Hansard - UK Parliament Report from the Steering Group for the National Review of the Hospital Standardised Mortality Ratio (nationalarchives.gov.uk)	
Improving NHS culture and governance	16	The Department of Health should consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role at Stafford hospital with the objective of learning lessons about how failing hospitals are identified	A public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire NHS Foundation Trust was announced by the Department of Health on 9 June 2010.	Independent Inquiry of the commissioning, supervisory and regulatory bodies in relation to Mid-Staffordshire NHS	

Mid-Staffordshire Independent Inquiry					
			The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published in February 2013.	Foundation Trust : Department of Health - Publications (nationalarchives.gov.uk)	
Improving NHS culture and governance	17	The Trust and the Primary Care Trust should consider steps to enhance the rebuilding of public confidence in the Trust.	In a June 2011 report to the Trust Board, it was said that a communication strategy had been developed to raise the profile of the Trust values, but events in 2010/11 had meant it was difficult to publicise such strategy.	Papers for Mid Staffordshire NHS Foundation Trust Board Meeting, 30 June 2011 (nationalarchives.gov.uk)	
Improving patient safety	18	All NHS trusts and foundation trusts responsible for the provisions of hospital services should review their standards, governance and performance in the light of this report	Level of implementation unknown.		

16 THE MID-STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

16.1 Introduction

A statutory inquiry set up in relation to serious failings in the standard of care at Mid-Staffordshire NHS Foundation Trust between January 2005 and March 2009. The Inquiry was chaired by Sir Robert Francis QC. The report of the Inquiry was delivered in February 2013. The report can be viewed online.

The Inquiry was tasked with:

- Examining the operation of the commissioning, supervisory and regulatory organisations and other agencies in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009;
- Examining why problems at the Trust were not identified sooner; and
- Making recommendations as to how in the future the NHS and the bodies which regulated it could ensure that failing and potentially failing hospitals or their services were identified as soon as possible.

The Inquiry identified serious failings within the Trust and in the various external agencies which were meant to regulate and oversee it. The Trust lacked insight and awareness of the reality of the care being provided to patients. There was a culture of not being open with and not listening to patients, and the Trust was generally defensive in its reaction to criticisms. The board and other leaders reacted too slowly and downplayed the significance of concerns. Governance and accountability structures were poor. External agencies were found to have poorly defined responsibility and accountability, with a lack of effective communication across the healthcare system. Constant reorganisation had led to a loss of corporate memory. The result was organisations failing to place quality of care and patients at the heart of their work.

The Inquiry made 290 recommendations. The Government responded to the report of the Inquiry, and the recommendations it made, in its January 2014 report titled '*Hard Truths: The Journey to Putting Patients First'* and its February 2015 report titled '*Culture Change in the NHS: Applying the lessons of the Francis Inquiries'.*

16.2 Mid-Staffordshire Public Inquiry: Table of Recommendations

Mid-Staffordshire Public Inquiry					
Type of Recommendation	No.	Details of Recommendation	Implementation	Source	Extent of Implementation
Accountability for implementation of recommendations					
Improving NHS culture and governance	**1**	All commissioning, service provision, regulatory and ancillary organisations involved in healthcare should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, regularly but not less than once a year, publish in a report information regarding its process in relation to its planned actions. The Department of Health should collate information about its decisions and actions generally and publish regularly but not less than once a year the progress reported by other organisations. The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report. (February 2013)	This recommendation was accepted by the Government. Below are the publicly available reports from various relevant organisations concerning their response to the Inquiry and its recommendations. Central Government The Government published its initial response in March 2013. In January 2014, the Government published a two-volume report titled "*Hard Truths: The Journey to Putting Patients First"* responding to each recommendation made by the Inquiry. In February 2015, the Government published a further report, titled "*Culture Change in the NHS: Applying the lessons of the Francis Inquiries"*, which provided a progress update in relation to each recommendation made by the Inquiry. The government also commissioned six review groups to explore some of the issues raised by the Inquiry, namely	Central Government Patients First and Foremost: The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry Hard Truths: The Journey to Putting Patients First: Volume One Hard Truths: The Journey to Putting Patients First: Volume Two	

Mid-Staffordshire Public Inquiry

			the Keogh Review, the Berwick Report, the Cavendish Review, the Clwyd-Hart Review, the NHS Confederation review of the NHS hospitals' complaints system and the Children and Young People's Health Outcomes Forum Report. NHS England By a Board Paper dated September 2013, NHS England set out details of progress against the recommendations made by the Inquiry for which it considered itself the lead organisation. In February 2014, NHS England published a 1-year-on news release, summarising improvements made in the previous year. The NHS Commissioning Board The NHS Commissioning Board published an initial press release in February 2013 following publication of the Inquiry's report. The Care Quality Commission The Care Quality Commission published online news releases in February 2013 and February 2015 announcing respectively what it intended to do and what progress it had made in implementing the recommendations of the Inquiry. Monitor	Culture change in the NHS – Applying the lessons of the Francis Inquiries NHS England NHS England Board Paper September 2013 NHS England » The Francis Report: One Year On NHS Commissioning Board NHS England » NHS Commissioning Board promises fundamental change in response to Francis Report The Care Quality Commission	

Mid-Staffordshire Public Inquiry

			Monitor published a statement on 26 March 2013 in relation to the initial government response to the Inquiry. Healthwatch England Healthwatch England published an initial response to the recommendations of the Inquiry dated 26 March 2013. The Health and Care Professions Council The Health and Care Professions Council considered a paper from its executive in March 2013 and a further paper in May 2013 which contained its policy statement. An update was published in July 2014. The General Medical Council The General Medical Council published an initial response, which is undated. A 6-month update was published in October 2013. A further update was published in April 2014. A third and final update was published in October 2014. The Nursing and Midwifery Council The Nursing and Midwifery Council published a formal response in July 2013. In March 2014, the Nursing and Midwifery Council published an update report. Royal Colleges	Care Quality Commission response to Francis Report - Care Quality Commission Care Quality Commission reports on 'Hard Truths' progress - Care Quality Commission (2015, last updated 2022) Monitor Mid Staffordshire public inquiry report: Monitor statement to government's initial response (2013) Healthwatch England Healthwatch England - Francis Position Statement	

Mid-Staffordshire Public Inquiry

			The Royal College of Surgeons published a response in March 2013. The Royal College of Nursing published a response to the Inquiry in July 2013. The Royal College of Physicians published a response to the Inquiry in September 2013 The Health Select Committee The Health Select Committee agreed to monitor implementations of recommendations and to enhance scrutiny of regulation of healthcare professionals by taking public evidence each year from the Professional Standards Authority for Health and Social Care on the regulatory environment and performance of each professional regulator. The Select Committee published a report "*After Francis: making a difference"* in September 2013.	The Health & Care Professions Council HCPC July 2014 update The General Medical Council The General Medical Council response to the report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry. An update on the GMC's work to address the Francis Recommendations GMC - April 2014 update on the Francis Recommendations October 2014 update on the GMC's work to	

Mid-Staffordshire Public Inquiry

				address the Francis Recommendations The Nursing and Midwifery Council NMC response to the Francis report 6-months-on-francis-update Royal Colleges RCS view on the Mid-Staffordshire public inquiry RCN-response-to-Francis-Inquiry-Report RCP response to the Francis Inquiry - detailed report The Health Select Committee After Francis: making a difference	

Mid-Staffordshire Public Inquiry					
Improving NHS culture and governance	**2**	The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires: • A common set of core values and standards shared throughout the system; • Leadership at all levels from ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards; • A system which recognises and applies the values of transparency, honesty and candour. • Freely available, useful, reliable and full information on attainment of the values and standards. • A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said it would continue to promote the core values and expectations for the NHS set out in the NHS Constitution. The Government referred to the publication of a values-based recruitment framework; incorporation of fundamental standards of safety and quality into the requirements for providers registered with the Care Quality Commission; the launching of NHS Leadership Academy Programmes; launch of an executive fast-track programme; publication of safety and outcomes data on the 'myNHS' website; introduction of the statutory duty of candour; and the new inspection model adopted by the Care Quality Commission, including the assessment of how well-led an organisation is.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Putting the patient first					
Improving NHS culture and governance	**3**	The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations and obligations of patients. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said it recognised that levels of awareness of the NHS Constitution were low among patients, public and staff. The Government referred to work by the Department of Health, NHS England, Health Education England and clinical commissioning groups to promote the NHS Constitution across the system.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the	

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			The Department of Health said it sought advice from an independent expert advisory group about how to increase impact and raise awareness of the NHS Constitution amongst the public and patients. Their advice was published in a report to the Secretary of State for Health and other relevant bodies on 13 March 2014. The Department of Health said it published a guide to help patients and the public understand how to give feedback and make complaints if standards described in the NHS Constitution were not met. Health Education England hosts a 'NHS constitutional values hub' the aim of which is to collect best practice and resources to help healthcare staff and organisation better understand the NHS Constitution. The Department of Health said it would continue working with key partners to consider ways to increase the impact of the NHS Constitution.	Francis Inquiries: Supporting Annex The NHS constitutional values hub | Health Education England	
Improving NHS culture and governance	**4**	The core values expressed in the NHS constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos. (February 2013)	This recommendation was accepted by the Government. The Department of Health published an updated NHS Constitution on 26 March 2013, which contained text explicitly stating that "*patients come first in everything we do*". This weas amended to "*The patient will be amended at the heart of everything the NHS does*" in July 2015.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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				NHS England » Updated NHS Constitution published	
Improving NHS culture and governance	**5**	In reaching out to patients, consideration should be given to including expectations in the NHS Constitution that: (i) Staff put patients before themselves. (ii) They will do everything in their power to protect patients from avoidable harm. (iii) They will be honest and open with patients regardless of the consequences for themselves. (iv) Where they are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so. (v) They will apply the NHS values in all their work. (February 2013)	This recommendation was accepted by the Government. The Government published its response to a consultation on amending the NHS Constitution in July 2015. These expectations are now included in the NHS Constitution under the heading "*Staff: your responsibilities*".	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex A consultation on updating the NHS Constitution: Government response The NHS Constitution for England	
Improving NHS culture and governance	**6**	The handbook to the NHS Constitution should be revised to include a much more prominent reference to the NHS values and their significance.	This recommendation was accepted by the Government.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		(February 2013)	A revised handbook was published in March 2013 and again in July 2015. The first substantive section sets out and explains the NHS values.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Handbook to the NHS Constitution for England	
Improving NHS culture and governance	**7**	All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment. (February 2013)	This recommendation was accepted by the Government in principle. In the January 2014 Hard Truths report, the Government said the Department of Health would commission NHS Employers to support NHS organisation in strengthening local policies on appraisal and performance management so that there was a clear line of sight between the NHS values, the NHS Constitution and performance and appraisal systems. It is unclear whether any amendments to contracts of employment were made.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**8**	Contractors providing outsourced services should be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that NHS England published a New Standard Contract in December 2014 to strengthen the requirements on all	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		be included in the terms on which providers are commissioned to provide services. (February 2013)	providers of commissioned healthcare services, including staff and sub-contractors, to abide by the NHS Constitution.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Fundamental standards of behaviour					
Improving NHS culture and governance **Regulation and oversight of NHS managers**	**9**	The NHS Constitution should include reference to all the relevant professional and managerial codes by which NHS staff are bound, including the Code of Conduct for NHS Managers. (February 2013)	This recommendation was accepted by the Government in principle. The NHS Constitution includes a general requirement for staff to aim to follow all guidance, standards and codes relevant to one's role. The Handbook gives examples of where those codes can be found, but does not include express reference to them. The Government response explained this was because the NHS Constitution was intended to be a succinct and enduring document.	Hard Truths: The Journey to Putting Patients First: Volume Two The NHS Constitution for England	
Improving NHS culture and governance	**10**	The NHS Constitution should incorporate an expectation that staff will follow guidance and comply with standards relevant to their work, such as those produced by National Institute for Health and Care Excellence and, where relevant, the Care Quality Commission, subject to any more specific requirements of their employers. (February 2013)	This recommendation was accepted by the Government in principle. The NHS Constitution includes a general requirement for staff to aim to follow all guidance, standards and codes relevant to one's role. The Handbook gives examples of where those codes can be found, but does not include express reference to them.	Hard Truths: The Journey to Putting Patients First: Volume Two The NHS Constitution for England	

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Improving NHS culture and governance	**11**	Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manger within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedure for as many interventions and pathways as possible. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to its enactment of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Government said that the Care Quality Commission had worked with healthcare professionals, including their Royal Colleges and their facilities, as well as providers, the public and other stakeholders throughout the development of its new regulatory approach.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**12**	Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government agreed that it was important staff receive feedback on any concerns they raise about patient safety. In the February 2015 Culture Change report, the Government said that rates of patient safety incident reporting had increased from 2012 to 2013. The Government referred to the publication by NHS England of a new indicator on the NHS Choices website, rating NHS hospitals of their incident reporting. The Government said this provided patients with authoritative and easy to access information on how well developed an organisation's patient safety incident reporting culture was.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			The Government said that the Care Quality Commission was giving greater prominence to safety alerts in its revised surveillance model, with its acute intelligent monitoring system including a composite indicator around completion of safety alerts which contributed to providers' risk scores. The Government also referred to then ongoing work to recommission the National Reporting and Learning System, with procurement to progress in 2015/16.		
A common culture made real throughout the system – an integrated hierarchy of standards					
Improving NHS culture and governance	**13**	Standards should be divided into: (i) fundamental standards of minimum safety and quality, in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. (ii) Enhanced quality standards, setting requirements higher than fundamental standards but being discretionary matters for commissioning. (iii) Developmental standards, which set out longer term goals for providers. (February 2013)	This recommendation was accepted by the Government. Fundamental standards were implemented via the Health and Social Care Act 2008 (Regulated Activities)) Regulations 2014, regs. 8 to 20A, in force from April 2015. Twelve fundamental standards. Every registered healthcare provider of NHS services required to comply with these requirements. In the January 2014 Hard Truths report, the Government considered that enhanced quality standards were already provided by guidance published by the National Institute for Health and Care Excellence. In the February 2015 Culture Change report, the Government said that the National Institute for Health and Care Excellence had published a consultation on its updated quality standards process which made detailed proposals for how developmental standards would be identified and produced, and that the National Institute for	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	

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			Health and Care Excellence had introduced developmental statements in its quality standards where appropriate.		
Improving NHS culture and governance	**14**	In addition to the fundamental standards of service, the regulations should include generic requirements for a governance system designed to ensure compliance with fundamental standards, and the provision and publication of accurate information about compliance with the fundamental and enhanced standards. (February 2013)	This recommendation was accepted by the Government in principle. Requirements for good governance systems were implemented via reg. 17 of the Health and Social Care Act 2008 (Regulated Activities)) Regulations 2014, in force from April 2015. The regulations also introduced a duty of candour.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	
Improving NHS culture and governance	**15**	All the required elements of governance should be brought together into one comprehensive standard. This should require not only evidence of a working system but also a demonstration that it is being used to good effect. (February 2013)	This recommendation was accepted by the Government in principle. Requirements for good governance systems were implemented via reg. 17 of the Health and Social Care Act 2008 (Regulated Activities)) Regulations 2014, in force from April 2015. It is not clear that this would amount to one comprehensive standard for all the required elements of governments.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			One of the 5 domains in which the Care Quality Commission provides a rating is whether the organisation is "*well-led*".	The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	
Improving NHS culture and governance	**16**	The Government through regulation, but after so far as possible achieving consensus between the public and professional representatives, should provide for the fundamental standards which should define outcomes for patients that must be avoided. These should be limited to those matters that it is universally accepted should be avoided for individual patients. (February 2013)	This recommendation was accepted by the Government. Fundamental standards were implemented via the Health and Social Care Act 2008 (Regulated Activities)) Regulations 2014, regs. 8 to 20A, in force from April 2015. The Care Quality Commission undertook a public consultation before drawing up the standards, engaging with both individuals and organisations including the medical and nursing Royal Colleges and the Nursing and Midwifery Council. The Department of Health also consulted on the regulations implementing fundamental standards.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	
Improving NHS culture and governance	**17**	The NHS Commissioning Board together with the Clinical Commissioning Groups should devise enhanced quality standards designed to drive improvement in the health services. Failure to comply with such standards should be a matter for performance management by commissioners rather than the regulator, although the latter should be charged with enforcing the provision by	The Government accepted this recommendation in principle. In the January 2014 Hard Truths report, the Government decided that the enhanced quality standards would be represented by the existing quality standards developed by the National Institute for Health and Care Excellence. The Government said that the National Institute for Health and	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the	

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		providers of accurate information about compliance to the public. (February 2013)	Care Excellence had introduced developmental statements in its quality standards where appropriate. The Government said that NHS England and clinical commissioning groups would have regard to enhanced quality standards in the way they commissioned services and the Care Quality Commission to use them to inform rating of providers. In the February 2015 Culture Change report, the Government also referred to the Care Quality Commission and Monitor working together to assess the capability of foundation trusts and/or their leadership to ensure safe and quality care, with both having a single, overarching framework for judging whether or not an organisation/service were well-led. The Care Quality Commission's inspection was to provide a judgment on the quality of services and Monitor was to take action where necessary to support improvement.	Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**18**	It is essential that professional bodies in which doctors and nurses have confidence are fully involved in the formulation of standards and in the means of measuring compliance. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Care Quality Commission had worked with healthcare professionals, including the Royal Colleges and their faculties, providers, the public and other stakeholders in developing its new regulatory approach. In the February 2015 Culture Change report, the Government also referred to the Care Quality Commission's new inspections involving healthcare professionals as part of the inspection teams as	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			well as joint agreements between the Care Quality Commission and strategic partner organisations.		
Responsibility for, and effectiveness of, healthcare standards					
Improving NHS culture and governance	**19**	There should be single regulator dealing both with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts. (February 2013)	This recommendation was rejected by the Government. In the January 2014 Hard Truths report, the Government took the position that there should be a single regulatory process, as opposed to a single regulator. The Care Quality Commission, Monitor, and the NHS Trust Development Authority were to make up that regime, keeping the role of inspecting Trusts separate from responsibility for the turnaround of failing organisations. Intervention was to be the role of Monitor or the NHS Trust Development Authority, unless patients and service users were at immediate risk of harm. In the February 2015 Culture Change report, the Government said that the Care Quality Commission and Monitor would work together closely to assess capabilities of a foundation trust to ensure safe and quality care, with Monitor making the assessment from the Board Down and the Care Quality Commission from the ward up. The Government said that the Care Quality Commission and Monitor would use a new single, overarching framework for judging whether an organisation/service was well-led and that the Care Quality Commission and Monitor would communicate information with each other.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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Improving NHS culture and governance	**20**	The Care Quality Commission should be responsible for policing the fundamental standards, through the development of its core outcomes, by specifying the indicators by which it intends to monitor compliance with those standards. It should be responsible not for directly policing compliance with any enhanced standards but for regulating the accuracy of information about compliance with then. (February 2013)	The Government accepted this recommendation in part. The Care Quality Commission was made responsible for policing the fundamental standards, primarily through inspection. Guidance on the fundamental standards, including indicators by which it monitors compliance, were first published in April 2015. The Care Quality Commission were given a range of enforcement options in the event of non-compliance, including prosecution or withdrawal of registration. However, other than through its inspections giving a view on overall quality and safety, and considering specific enhanced standards, the Care Quality Commission would not be responsible for regulating the accuracy of information and compliance with enhanced standards, which was to be the role of commissioners.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Regulations for service providers and managers - Care Quality Commission	
Improving NHS culture and governance	**21**	The regulator should have a duty to monitor the accuracy of information disseminated by providers and commissioners on compliance with standards and their compliance with the requirement of honest disclosure. The regulator must be willing to consider individual cases of gross failure as well as systemic causes for concern. (February 2013)	The Government accepted this recommendation in principle. In the January 2014 Hard Truths report, the Government referred to the Care Quality Commission's powers to require information and explanations, as well as its system of intelligent monitoring to help decide when, where and what to inspect. The Government said this drew information and data from a range of sources, which enabled it to cross-refer concerns and build up a picture of care. The Government also said that it was a condition of Monitor's licence that information provided to Monitor was accurate, complete and not misleading.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			There was no mention of the Care Quality Commission being put under a duty to monitor the accuracy of information disseminated by providers.		
Improving NHS culture and governance	**22**	The National Institute for Health and Care Excellence should be commissioned to formulate standard procedures and practice designed to provide the practical means of compliance, and indicators by which compliance with both fundamental measures and enhanced standards can be measured. These measures should include both outcome and process based measures, and should as far as possible build on information already available within the system or on readily observable behaviour. (February 2013)	This recommendation was accepted by the Government in principle. In the January 2014 Hard Truths report, the Government referred to the introduction by the National Institute for Health and Care Excellence of developmental statements in its quality standards where appropriate. In the February 2015 Culture Change report, the Government also referred to the 2014 Memorandum of Understanding between the Care Quality Commission and the National Institute for Health and Care Excellence, which set out areas of cooperation between the two organisations, including development of guidance, advice and other tools by the National Institute for Health and Care Excellence, and the Care Quality Commission's support for the development of such guidance, quality standards and indicators.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**23**	The measures formulated by the National Institute for Health and Care Excellence should include measures not only of clinical outcomes, but the suitability and competence of staff, and the culture of organisations. The standard procedures and practice should include evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix.	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the National Institute for Health and Care Excellence was working over a 3-year period on guidance on safe staffing in nine different settings.	Hard Truths: The Journey to Putting Patients First: Volume Two Overview | Safe staffing for nursing in adult inpatient	

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		This should include nursing staff on wards as well as clinical staff. These tools should be created after appropriate input from specialities, professional organisations, and patient and public representatives, and consideration of the benefits and value for money of possible staff : patient ratios. (February 2013)	The National Institute for Health and Care Excellence published guidance on safe staffing levels for nursing in adult inpatient wards in acute hospitals in July 2014. Guidance on safe midwifery staffing for maternity settings was published in February 2015. In June 2015, the National Institute for Health and Care Excellence's work on safe staffing levels was suspended. The Government did not explicitly respond to the recommendation for measures relating to the culture of organisations.	wards in acute hospitals | Guidance | NICE Overview | Safe midwifery staffing for maternity settings | Guidance | NICE	
Improving NHS culture and governance	**24**	Compliance with regulatory fundamental standards must be capable so far as possible of being assessed by measures which are understood and accepted by the public and healthcare professionals. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Care Quality Commission had consulted on how it planned to change the way it regulated, included hearing from members of the public and organisations that represent people who use services. The Government also referred to the Chief Inspectors at the Care Quality Commission engaging with the public and giving attention to how the fundamental standards of care are presented to the public.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**25**	It should be considered the duty of all speciality professional bodies, ideally together with the National Institute of Health and Care Excellence, to develop measures of outcome in relation to their	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Academy of Royal Medical Colleges and Faculties and the National Institute of Health and Care Excellence were working together to agree and implement	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		work and to assist in the development of measures of standards compliance. (February 2013)	how medical and other colleges would contribute to the development of outcome measures. In the January 2014 Hard Truths report, the Government referred to the Royal Colleges working with the Care Quality Commission on their contribution to the regulator's standards and inspection processes; the Colleges being involved with NHS England in the publication of consultant treatment outcomes data for specific specialities; and development of the Colleges' supported service accreditation schemes.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**26**	In policing compliance with standards, direct observation of practice, direct interaction with patients, carers and staff, and audit of records should take priority over monitoring and audit of policies and protocols. The regulatory system should retain the capacity to undertake in-depth investigations where these appear to be required. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Care Quality Commission had implemented a new inspection regime, with use of specialist inspectors. These were to include 'listening events' prior to each inspection. Inspection teams would interview directors of the trust and staff at all levels, at a minimum interviewing the chair, chief executive, medical director, director of nursing, chief operating officer, director of finance, non-executive director responsible for quality/safety, board director responsible for end-of-life care, service leads for the core services and the complaints lead. There would also be focus groups and individual interviews for junior doctors and other members of staff. During inspections, time would be spent to those who use the service.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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Improving NHS culture and governance	**27**	The healthcare systems regulator should promote effective enforcement by use of a low threshold of suspicion; no tolerance of non-compliance with fundamental standards; and allowing no place for favourable assumptions, unless there is evidence showing that suspicions are ill-founded or that deficiencies have been remedies. (February 2013)	This recommendation was accepted by the Government. Breaches of regs. 11, 16(3), 17(3), 20(2)(a), 20(3) and 20A of the Social Care Act 2008 (Regulated Activities) Regulations 2014 were made prosecutable without the need for a warning notice or harm. In the February 2015 Culture Change report, the Government referred to the Care Act 2014 as creating an additional form of warning notice which the Care Quality Commission could issue when it judged a trust required significant improvement. The Government did not explicitly state what threshold would be used and whether a no-tolerance approach would be adopted nor how.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Offences - Care Quality Commission	
Improving NHS culture and governance	**28**	A service incapable of meeting fundamental standards should not be permitted to continue. Breach should result in regulatory consequences attributable to an organisation in the case of a system failure and to individual accountability where individual professionals are responsible. Where serious harm or death has resulted to a patient as a result of breach of the fundamental standards, criminal liability should follow and should also attract regulatory consequences. Breaches not resulting in actual harm but which have exposed patients to a continuing risk of harm to which they would not otherwise have been exposed should also be regarded as unacceptable. (February 2013)	This recommendation was accepted by the Government by the Government. Breaches of regs. 11, 16(3), 17(3), 20(2)(a), 20(3) and 20A of the Social Care Act 2008 (Regulated Activities) Regulations 2014 were made prosecutable without the need for a warning notice or harm. The Care Quality Commission's powers in relation to breach of fundamental standards included: • The ability to refuse registration if providers are unable to satisfy it that they can and will continue to comply with the fundamental standards.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Offences - Care Quality Commission	

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			• The ability to recommend that the NHS Trust Development Authority or Monitor pace the Trust into special measures. • The ability to prosecute for breach of certain fundamental standards where a patient has been exposed to avoidable harm or a significant risk of harm occurring. In the January 2014 Hard Truths report, the Government also referred to Monitor's powers for breach of licence conditions and the ability of professional regulators to take decisions to remove clinical practitioners through fitness to practise procedures.		
Improving patient safety	**29**	It should be an offence for death or serious injury to be caused to a patient by breach of these regulatory requirements, or, in any other case of breach, where a warning notice in respect of the breach has been served and the notice has not been complied with. It should be a defence for the provider to prove that all reasonably practicable steps have been taken to prevent a breach, including having in place a prescribed system to prevent such a breach. (February 2013)	The Government accepted this recommendation. Breaches of regs. 11, 16(3), 17(3), 20(2)(a), 20(3) and 20A of the Social Care Act 2008 (Regulated Activities) Regulations 2014 were made prosecutable without the need for a warning notice or harm. Breaches of regs. 12 to 14 were made prosecutable if the breach resulted in patients being exposed to avoidable harm, significant risk of harm occurring or loss of money/property. This included a power to prosecute for failure to provide safe care and treatment.	Hard Truths: The Journey to Putting Patients First: Volume Two Offences - Care Quality Commission	

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			Reg. 22(4) provided a defence of proving that all reasonable steps were taken and all due diligence exercise to prevent the breach of the regulations which occurred.		
Improving NHS culture and governance	**30**	The healthcare regulator must be free to require or recommend immediate protective steps where there is reasonable cause to suspect a breach of fundamental standards, even if it has yet to reach a concluded view or acquire all the evidence. The test should be whether it has reasonable grounds in the public interest to make the interim requirement or recommendation. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Care Quality Commission would retain its ability to stop a service from providing care if it had reasonable cause to believe that unless it acts people may be exposed to the risk of harm. In the February 2015 Culture Change report, the Government also referred to the Care Act 2014, which created an additional form of warning notice for NHS trusts and foundations trusts.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**31**	Where aware of concerns that patient safety is at risk, Monitor and all other regulators of healthcare providers must have in place policies which ensure that they constantly review whether the need to protect patients requires use of their powers of intervention to inform a decision whether or not to intervene, taking account of, but not being bound by, the views or actions of other regulators. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the establishment of Quality Surveillance Groups in April 2013 to bring together commissioners, regulators, local Healthwatch representatives and other bodies on a regular basis to share information and intelligence about quality across the system. The Care Quality Commission was to monitor evidence and information to detect if a provider is performing outside of what would be expected. The NHS Trust Development Authority published a paper in April 2013, outlining the oversight model they would use to hold non-Foundation trusts to account. The Government referred to Monitor	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			continuing to assess breaches to tis licence system. Monitor would use a risk-based system of regulation, with forma weekly process to review the need for intervention, if required. In the February 2015 Culture Change report, the Government also referred to the new special measures regime, which it said allowed the NHS Trust Development Authority and Monitor to intervene at providers which the Care Quality Commission judged to be providing poor quality care.		
Improving NHS culture and governance	**32**	Where patient safety is believed on reasonable grounds to be at risk, Monitor and any other regulator should be obliged to take whatever action within their powers is necessary to protect patient safety. Such action should include, where necessary, temporary measures to ensure such protection while any investigation required to make a final determination is undertaken. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the Care Quality Commission retaining its ability to impose enforcement action as well as stop the provision of a service where it is putting people at immediate risk of harm; as well as Monitor and the NHS Trust Development Authority retaining their powers to intervene at their discretion if urgent action is required. In the February 2015 Culture Change report, the Government also referred to the new special measures regime, which it said allowed the NHS Trust Development Authority and Monitor to intervene at providers which the Care Quality Commission judged to be providing poor quality care.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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Improving NHS culture and governance	**33**	Insofar as a healthcare regulator considers they do not possess any necessary interim powers, the Department of Health should consider introduction of the necessary amendments to legislation to provide such powers. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said that the Care Quality Commission already had the power of immediate intervention and the NHS Trust Development Authority and Monitor each had power to intervene and direct change when considered necessary. The Government referred to the power of the Care Quality Commission to take enforcement without prior warning notice in respect of breaches of certain fundamental standards. In the February 2015 Culture Change report, the Government also referred to the new special measures regime, which it said allowed the NHS Trust Development Authority and Monitor to intervene at providers which the Care Quality Commission judged to be providing poor quality care.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**34**	Where a provider is under regulatory investigation, there should be some form of external performance management involvement to oversee any necessary interim arrangements for protecting the public. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said that where the Care Quality Commission issued an enforcement notice, it was the role of Monitor or the NHS Trust Development Authority to ensure that it was complied	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the	

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			with. However, it remained the responsibility of providers' boards to identify and resolve risks. In the February 2015 Culture Change report, Government also referred to the new special measures regime, which it said allowed the NHS Trust Development Authority and Monitor to intervene at providers which the Care Quality Commission judged to be providing poor quality care. This included partnering the failing provider with a high-performing buddy, the appointment of a dedicated improvement director at the trust as well as other targeted interventions.	Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**35**	Sharing of intelligence between regulators needs to go further than sharing of existing concerns identified as risks. It should extent to all intelligence which when pieced together with the possessed by partner organisations may raise the level of concern. Work should be done on a template of the sort of information each organisation would find helpful. (February 2013)	The Government accepted this recommendation. In the January 2014 Hard Truths report, the Government referred to the establishment of Quality Surveillance Groups in April 2013 to bring together commissioners, regulators, local Healthwatch representatives and other bodies on a regular basis to share information and intelligence about quality across the system. Although central information was not collected on the performance of Quality Surveillance Groups, the Government said that anecdotal information suggestion that they had bedded into many parts of the country. In the February 2015 Culture Change report, the Government referred to memoranda of understanding between the General Medical Council and the Care Quality Commission, and the Nursing and Midwifery Council and	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			the Care Quality Commission as ensuring the sharing of information. The Government said that as part of this agenda, the Care Quality Commission would use a range of information from regulators and partners to support surveillance processes; contact professional regulators to request relevant intelligence to inform them of inspections; share intelligence with Monitor; and send any notices regarding performance to Monitor and the NHS Trust Development Authority.		
Improving NHS culture and governance	**36**	A coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real time as possible, and should be capable of use by regulators in assessing the risk of non-compliance. It must not only include statistics about outcomes, but must take advantage of all safety related information, including that capable of being derived from incidents, complaints and investigations. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the Health and Social Care Act 2012 which required the Health and Social Care Information Centre to establish and operate a system for the collection of analysis of information in connection with the provision of health services and adult social care in England. The Health and Social Care Centre was established in April 2013 and the Government said it published more than 130 statistical publications annually via its website, as well as a range of national indicators and metrics, many of which were available publicly through its indicator portal. In the February 2015 Culture Change report, the Government said that the National Information Board ensured that the Health and Social Care Information Centre was the focal point for data collected at the national level, and the Centre would continue to look for opportunities for standardising statistical outputs. The Government said that a Health & Social Care Digital Service would be replacing	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			NHS Choices, which would bring together data from national web services.		
Improving NHS culture and governance	**37**	Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them. To the extent that it is not practical in a written report to set out detail, this should be made available via each trust's website. Reports should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information. To make or be party to a wilfully or recklessly false statement as to compliance with safety or essential standards in the required quality account should be made a criminal offence. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government agreed that reports should not be confined to achievements and should reflect a balanced view of quality. In the February 2015 Culture Change report, the Government said that a review of Quality Accounts had taken place, with 180 stakeholders being involved. The Government said that, as a result of the review, the purpose of Quality Accounts had been updated to reflect the need for openness and honesty and a Quality Accounts Data Dictionary was developed and published in March 2014 to improve the consistency of indicator data and definitions. Current NHS guidance requires every quality account to have a signed statement from the most senior manager of the organisation, declaring they are happy with its accuracy and are aware of the quality of the NHS services provided.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex NHS England » Quality accounts FAQs	
Improving NHS culture and governance	**38**	The Care Quality Commission should ensure as a matter of urgency that it has reliable access to all useful complaints information relevant to assessment of compliance with fundamental standards, and should actively seek this information out. Any bureaucratic or legal obstacles to this should be removed. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the Care Quality Commission already having a customer service centre which received comments from the public, and that it ensured these comments were fed into inspections. The Government said that no legal obstacles to the Care Quality Commission accessing information had been identified and any bureaucratic obstacles to	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			information sharing were being addressed through the development of information sharing protocols. The Care Quality Commission published its 'Complaints Matter' report in December 2014. It set out its 'Intelligent Monitoring' process, which used various indicators including negative patient comments, complaints received by the Care Quality Commission and provider complaints. Information relating to complaints from providers would include numbers of complaints, their themes and timeliness of resolution. The Care Quality Commission also set out the contact before site inspections its local inspections team would make, in order to find out more about concerns and complaints and how these are handled. During the site visit, the member of staff with responsibility for complaints would be interviewed.	Complaints Matter Report, CQC, December 2014	
Improving NHS culture and governance	**39**	The Care Quality Commission should introduce a mandated return form from providers about patterns of complaints, how they were dealt with and outcomes. (February 2013)	This recommendation was accepted by the Government in principle. In the January 2014 Hard Truths report, the Government said that as part of its new inspection regime, the Care Quality Commission would ensure it has access to information concerning complaints, which would also inform the timing and focus of its inspections. Reference to a two-way memorandum of understanding with Monitor to allow sharing of patient complaints information. The Government said it would delay the decision on requiring mandatory information until the implications of the Clwyd/Hart Review of the Handling of Complaints in NHS Hospitals was fully understood, the NHS Confederation's	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			review of bureaucracy report was published, and the Care Quality Commission had evaluated its information requirements. In the February 2015 Culture Change report, the Government said that Care Quality Information would ask providers to share any survey they had carried out of people who have complained to them in the last 12 months.		
Improving NHS culture and governance	**40**	It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the new inspection approach of the Care Quality Commission placed a stronger focus on how care was delivered in practice, and how it was experienced, rather than just compliance with regulations. In the February 2015 Culture Change report, the Government referred to the Care Quality Commission using listening and focus groups, interviews with complaints managers and possible looking through the complaints file in order to look at the whole complaints process. The Government said that mandatory key line of inquiries in the October 2014 Care Quality Commission provider handbooks included asking how people's concerns and complaints were listened and responded to and whether they were used to improve the quality of care. The Government said that the Care Quality Commission planned to carry out an audit of randomly selected closed files to understand if they had been handled in a way that matches good practice.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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Improving NHS culture and governance	**41**	The Care Quality Commission should have a clear responsibility to review decisions not to comply with patient safety alerts and to oversee the effectiveness of any action required to implement them. Information-sharing with the Care Quality Commission regarding patient safety alerts should continue following the transfer of the National Patient Safety Agency's functions in June 2012 to NHS Commissioning Board. (February 2013)	The Government accepted this recommendation in principle. In the January 2014 Hard Truths report, the Government said that the Care Quality Commission was giving greater prominence to safety alerts in its revised surveillance model, with the Intelligent Monitoring system including a composite indicator around completion of safety alerts which contributed to providers' risk scores. However, the Government said that care was needed to be clear that providers retained accountability for implementing patient safety alerts, with it not being the Care Quality Commission's role to oversee their individual decisions or actions.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**42**	Strategic Health Authorities/their successors should, as a matter of routine, share information on serious untoward incidents with the Care Quality Commission. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that information on serious untoward incidents was shared routinely with the Care Quality Commission and Quality Surveillance Groups had been established in April 2013 to support the sharing of information at local level. Quality Surveillance Groups shared information and intelligence on the quality of care between commissioners, regulators and all local NHS organisations, including untoward incidents and their management. The Government also said that NHS England (the relevant successor to Strategic Health Authorities in this context) continued to share with the Care Quality Commission information on serious untoward incidents reported to the	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			Strategic Executive Information System and National Reporting and Leaning System. In the February 2015 Culture Change report, the Government referred to the Care Quality Commission's Intelligent Monitoring tool, which would analysis information including that from the National Reporting and Learning System and statutory returns to the Care Quality Commission.		
Improving NHS culture and governance	**43**	Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they responsibility. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Care Quality's Commissions new inspection approach would include monitoring media reports which would contribute to decisions on when and where to inspect. The Government also referred to Monitor, the NHS Trust Develop Authority, NHS England, the Nursing and Midwifery Council and the General Medical Council all monitoring media reports. The Government said in the February 2015 Culture Change report that the Care Quality Commission was reviewing how it used media stories as source of intelligence.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**44**	Any example of a serious incident or avoidable harm should trigger an examination by the Care Quality Commission of how that was addressed by the provider and a requirement for the trust concerned to demonstrate that the learning to be derived has been successfully implemented. (February 2013)	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, the Government referred to the Care Quality Commission's new inspection regime, in which indicators used for monitoring quality would use information on serious untoward incidents and avoidable harm. However, the Government said it would	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the	

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			not be feasible to follow up on every reported incident of patient harm as there more than 250,000 incidents each year. The Government said that the Care Quality Commission had defined a number of these indicators as 'tier one indicators' (including serious incidents such as 'never events') which would trigger rigorous follow-up action to obtain assurance. In the February 2015 Culture Change report, the Government referred to the Care Quality Commission' new Intelligent Hospital Monitoring system, which would trigger a response where there is statistically significant number of severe harm incidents or avoidable deaths at a provider location. However, the Government also referred to the need to avoid duplication with local arrangements for ensuring that providers address serious incidents and avoidable harms, meaning that the Care Quality Commission should not follow up any serious incident or avoidable harm. In the 2015 Culture Change Report, the Government said that the Care Quality Commission was reviewing internally its role and approach to serious incident reporting and investigations.	Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**45**	The Care Quality Commission should be notified directly of upcoming healthcare-related inquests, either by trusts or coroners. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said that the Care Quality Commission was undertaking an analysis of the information available from coroners'	Hard Truths: The Journey to Putting Patients First: Volume Two	

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			investigations and inquests, with a view to targeting requests for information from coroners. The Coroners' Society of England and Wales and the Care Quality Commission entered into a Memorandum of Understanding, whereby they agreed coroner should notify the Care Quality Commission as soon as is reasonably practicable of any inquest where concerns exist about the care or treatment received by a deceased.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Memorandum of Understanding: Coroners' Society of England and Wales and the CQC	
Improving NHS culture and governance	**46**	The Quality and Risk Profile should not be regarded as a potential substitute for active regulatory oversight by inspectors. It is important that this is explained carefully and clearly as and when the public are given access to the information. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the quality and risk profile approach had been replaced since October 2013, with the Care Quality Commission publishing its analysis of risk indicators for the entire hospital sector, showing how providers performed against the indicators. The Government referred to the Care Quality Commission's new inspection regime, with inspections based on identifying lines of enquiry from whatever quantitative and qualitative information suggestion about standards of care, rather than being focused on regulations.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**47**	The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors on appointment, inviting them to submit relevant information about any	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the Care Quality Commission taking steps to engage Overview and Scrutiny Committees and foundation	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		concerns to the Care Quality Commission. (February 2013)	trust Governors to increase their input to inspection and monitoring. All Overview and Scrutiny Committees were said to be receiving a two-monthly bulleting from the Care Quality Commission to update them on work and encourage feedback. The Government said that overview and scrutiny committees were to share information with Care Quality Commission gathered from local communities about the quality and safety of health and social care services. The Government said that Monitor's statutory guidance for Governors had been updated to set out ways in which Governors could share information. In the February 2015 Culture Change report, the Government said that the Care Quality Commission was developing a guide for local councillors and overview and scrutiny committees to working with the Care Quality Commission.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**48**	The Care Quality Commission should send a personal letter, via each registered body, to each foundation trust governor on appointment, inviting them to submit relevant information about any concerns to the Care Quality Commission. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government referred to the Chief Inspector of Hospitals writing to Foundation Trust Councils of Governors about the new wave of inspections and how governors could be involved in listening events, feed in information to inspections and at any time contact the Care Quality Commission. It was also agreed that Care Quality Commission methodology would invite relevant Council of Governors to contribute evidence as part of an inspection.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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Improving NHS culture and governance	**49**	Routing and risk-related monitoring, as opposed to acceptance of self-declarations of compliance, is essential. The Care Quality Commission should consider its monitoring in relation to the value to be obtained from: the Quality and Risk Profile, Quality Accounts, reports from Local Healthwatch, new or existing peer review schemes and themed inspections. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the Care Quality Commission's new inspection regime. The Government also said that the Care Quality Commission had begun a new approach to monitoring based on identification of certain indicators and that it had engaged in review of quality accounts. In the February 2015 Culture Change report, the Government referred to the Care Quality Commission's Intelligent Monitoring system, which looked at data from staff, patient surveys mortality rates and other hospital performance information. The Government said that the Care Quality Commission's Board agreed a new, strategic approach to thematic work in February 2014, to enable it to develop an independent voice through thematic activity on priority topics, with a view for thematic findings to inform its surveillance, inspection and ratings when appropriated.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**50**	The Care Quality Commission should retain an emphasis on inspection as a central method of monitoring non-compliance. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the Care Quality Commission's new inspection regime, which was said to involve large teams of specialists and public listening events, with a focus on quality of care rather than complained with regulations.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture change in the NHS – Applying	

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				the lessons of the Francis Inquiries	
Improving NHS culture and governance	**51**	The Care Quality Commission should develop a specialist cadre of inspector by thorough training in the principles of hospital care. Inspections of NHS hospital care providers should be led by such inspectors who should have the support of a team, including service user representatives, clinicians and any other specialism necessary because of particular concerns. Consideration should be given to applying the same principles to the independent sector, as well as to the NHS. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to 3 new roles – Chief Inspector of Hospitals, Chief Inspector of Primary Care and Chief Inspector of Adult Social Care —tasked to ensure that inspections were no longer a tick box exercise. The Care Quality Commission was said to have developed a new inspection framework which set out five domains against which to assess providers. New inspection regime. Inspection teams were to be made up of senior and junior doctors, nurses, allied health professionals, senior managers and people with experience of using hospital services.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture change in the NHS – Applying the lessons of the Francis Inquiries Chapter 3.	
Improving NHS culture and governance	**52**	The Care Quality Commission should consider whether inspections could be conducted in collaboration with other agencies, or whether they can take advantage of any peer review arrangements available. (February 2013)	This recommendation was accepted by the Government. The Care Quality Commission entered into joint working protocols with the Nursing and Midwifery Council (in 2015) and the General Medical Council (revised in December 2014). As to current versions, the Care Quality Commission – Nursing Midwifery Council joint working protocol makes explicit reference to involvement of the Nursing and Midwifery Council in the inspection regime, including information sharing and aligning of inspection and visiting activities. The Care Quality Commission – General Medical Council joint working protocol makes mention of exchange of information, but does not explicitly refer to inspections.	Hard Truths: The Journey to Putting Patients First: Volume Two Nursing and Midwifery Council - Care Quality Commission, Joint Working Protocol 11-2017-update-na General Medical Council - Care Quality Commission, Joint	

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			The Government also said in the February 2015 Culture Change report that the General Medical Council continued to send the Care Quality Commission information relating to individual trusts for use as part of the inspection process, which related to registration and revalidation, fitness to practise and education.	Working Protocol 6-August-2020	
Improving NHS culture and governance	**53**	Any change to the Care Quality Commission's role should be by evolution. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said there were no plans to abolish the Care Quality Information, but instead there would be a process of fundamental change, focussed on developing its new regulatory approach and giving it greater independence.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**54**	Where issues relating to regulatory action are discussed between the Care Quality Commission and other agencies, these should be properly recorded to avoid any suggestion of inappropriate interference in the Care Quality Commission's statutory role. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to implementation of this recommendation via partnership agreements and operational protocols which include criteria to make and store a formal record of meetings, including with Monitor, the NHS Trust Development Authority, Healthwatch England the General Medical Council. Such agreements were also agreed with the Local Government Ombudsman (agreed in late 2014) and the Parliamentary and Health Services Ombudsman (agreed in September 2013)	Hard Truths: The Journey to Putting Patients First: Volume Two Monitor - Care Quality Commission, Memorandum of Understanding, annexes 1-6 Nursing and Midwifery Council -	

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				Care Quality Commission, Joint Working Protocol 11-2017 General Medical Council - Care Quality Commission, Joint Working Protocol v7 6-August-2020 Memorandum of understanding between the PHSO and CQC CQC LGO Memorandum of Understanding, November 2014	
Improving NHS culture and governance	**55**	The Care Quality Commission should review its processes as a whole to ensure it is capable of delivering regulatory oversight and enforcement effectively. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that that an independent evaluation of the Care Quality Commission's new approach to inspection had been commission from the King's Fund and Manchester Business School. The final report was published in September 2018.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			In the February 2015 Culture Change report, the Government also said that the Care Quality Commission had commissioned Frontier Economics to undertake a review of its operations, including for it to develop a robust framework for assessing the costs and benefits of regulation.		
Improving NHS culture and governance	**56**	The leadership of the Care Quality Commission should communicate clearly and persuasively its strategic direction to the public and to its staff, with a degree of clarity that may have been missing to date. (February 2013)	This recommendation was accepted by the Government. The Government referred to various consultations which the Care Quality Commission undertook, including in autumn 2013 as to how fundamental standards of care, surveillance, inspection and monitoring should work; in spring 2014 on how it planned to change the way it regulated, inspected and rated care services; and in summer 2014 on its guidance for meeting the fundamental standards. The Care Quality Commission appears to continue to publish 3-year strategies.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**57**	The Care Quality Commission should undertake a formal evaluation of how it would detect and take action on the warning signs and other events giving caused for concern at the Trust described in this report, and in the report of the first inquiry, and open that evaluation for public scrutiny. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the Care Quality Commission carrying out a significant review of how it used information to identify potential failures in quality of care, seeking to define a set of indicators it could use. In the February 2015 Culture Change report, the Government said that the Care Quality Commission had put in place a system of Intelligent Monitoring to help decide	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			when, where and what to inspect, which would draw information from a range of sources to identify providers and services where there might be a greater risk of providing poor care.		
Improving NHS culture and governance	**58**	Patients, through their user group representatives, should be integrated into the structure of the Care Quality Commission. It should consider whether there is a place for patients' consultative council with which issues could be discussed to obtain a patient perspective directly. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the Chair of Healthwatch England sitting on the Care Quality Commission's Board. In the February 2015 Culture Change report, the Government said that the Care Quality Commission recruited and trained people who use services, known as 'Experts by Experience', to accompany inspection staff on inspections, as well as attend listening events, consultations, staff training events and take part in activities to develop the Care Quality Commission's strategy and processes. It is unclear whether a patient's consultative council or panel was ever constituted.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Panels and advisory groups - Care Quality Commission	
Improving NHS culture and governance	**59**	Consideration should be given to the introduction of a category of nominated board members form representatives of the professions, a representative of nursing and allied healthcare professionals, and patient representative groups. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the said that the Care Quality Commission had established a series of sector advisory groups, including senior representatives from Royal Colleges and patient groups. The Government said that the Care Quality Commission was considering whether this recommendation could	Hard Truths: The Journey to Putting Patients First: Volume Two How CQC works with Royal Colleges - Care Quality Commission	

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			provide a renewed impetus to its advisory committee as a statutory, advisory body to the board in order to ensure different perspectives were taken into account.		
Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions					
Improving NHS culture and governance **Regulation and oversight of NHS managers**	**60**	The Secretary of State should consider transferring the functions of regulating governance of healthcare providers and the fitness of persons to be directors, governors or equivalent persons from Monitor to the Care Quality Commission. (February 2013)	This recommendation was accepted by the Government in principle. In the January 2014 Hard Truths report, the Government said that the desired outcome was best achieved through closer cooperation between Monitor and the Care Quality Commission rather than through transfer of functions. However, the Government stated the Care Quality's inspection regime to include a focus on whether or not an organisation was well-led. In the February 2015 Culture Change report, the Government referred to the introduction of fit and proper persons test which gave the Care Quality the power to take action against directors (reg.5 of the Social Care Act 2008 (Regulated Activities) Regulations 2014). It does not apply to governors of a foundation trust. The Care Quality Commission was not given the power to bar directors nor to directly regulate individual directors. The task of acting upon the Fit and Proper Person test was left to the individual trusts.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	

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Improving NHS culture and governance	**61**	A merger of system regulatory functions between Monitor and the Care Quality Commission should be undertaken incrementally and after through planning. Such a move should not be used as a justification for reduction of the resources allocated to this area of regulatory activity. I would be vital to retain the corporate memory of both organisations. (February 2013)	This recommendation was not accepted by the Government in the January 2014 Hard Truths report. The Government did not merge regulatory functions through the development of a single regulator.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**62**	For as long as it retains responsibility for the regulation of foundation trusts, Monitor should incorporate greater patient and public involvement into its own structures, to ensure this focus is always at the forefront of its work. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to Monitor engaging with the Department of Health on recruitment of Medical Advisor and Director of Patient and Clinical Engagement, as well as development of patient engagement work strand. The Government said that Monitor's assessment process included review of patient and staff surveys, meetings with staff and patient groups, local media coverage, interviews with lead commissions external and internal auditors and writing to local MPs and Healthwatch. The Government also referred to Monitor working with patient representative bodies and using patient intelligence. In the February 2015 Culture Change Report, the Government said that Monitor had appointed a Director of Patient and Clinical Engagement in May 2014, as well as developed a good practice guide to guide patient engagement. "Patients first" was said to be one of Monitor's 5 values.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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Improving NHS culture and governance	**63**	Monitor should publish all side letters and any rating issued to trusts as part of their authorisation or licence. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that Monitor had published all side letters since 2011 and risk ratings on a quarterly basis.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**64**	The authorisation process should be conducted by one regulator, which should be equipped with the relevant powers and expertise to undertake this effectively. With due regard to protecting the public from the adverse consequences inherent to any reorganisation, the regulation of the authorisation process and compliance with foundation trust standards should be transferred to the Care Quality Commission, which should incorporate the relevant departments of Monitor. (February 2013)	This recommendation was not accepted by the Government in the January 2014 Hard Truths report. The Government did not merge regulatory functions through the development of a single regulator. However, the Government said that no provider would be authorised as a Foundation Trust unless the Care Quality Commission judged the quality of their services as good or outstanding.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**65**	The NHS Trust Development Authority should develop a clear policy requiring proof of fitness for purpose in delivering the appropriate quality of care a precondition to consideration for support for a foundation trust application. (February 2013)	This recommendation was accepted by the Government. The NHS Trust Development Authority published an accountability framework which set out the requirement that the achievement of Foundation Trust status would only be possible for trusts delivering the key fundamentals of clinical quality, good patient experience and national and local standards and targets.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex e.g. 2015/16 Accountability Framework	

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Improving NHS culture and governance	**66**	The Department of Health, the NHS Trust Development Authority and Monitor should jointly review the stakeholder consultation process with a view to ensuring that: (i) Local stakeholder and public opinion is sought on the fitness of a potential applicant NHS trust for foundation trust status and in particular on whether a potential applicant is delivering s sustainable service compliant with fundamental standards. (ii) An accessible record of responses received is maintained. (iii) The responses are made available for analysis on behalf of the Secretary of State and, where an application is assessed by it, Monitor.	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to Monitor's Assessment process including review of patient views, meetings with patient groups, local media coverage and interviews with lead commissioners. The Government said that the NHS Trust Development Authority would test trusts' patient and public involvement strategies to ensure they were engaging with patients and the local community throughout the foundation trust application process, particularly on the quality of care being provided, and that it would follow up with the trust on what it has done in response to any concerns raised, recording this feedback and sharing the information with Monitor as necessary. The Government said this was set out in the NHS Trust Development Authority Accountability Framework.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**67**	The NHS Trust Development Authority should develop a rigorous process for the assessment as well as the support of potential applications for foundation trust status. The assessment must include as a priority focus a review of the standard of service delivered to patients, and the sustainability of a service at the required standard. (February 2013)	This recommendation was accepted by the Government. The NHS Trust Development Authority published an accountability framework which set out the requirement that the achievement of Foundation Trust status would only be possible for trusts delivering the key fundamentals of clinical quality, good patient experience and national and local standards and targets. The process for assessing this would include information from public consultation, the Care Quality Commission, NHS England, the relevant clinical commissioning groups and other national and local system partners.	Hard Truths: The Journey to Putting Patients First: Volume Two e.g. 2015/16 Accountability Framework	

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Improving NHS culture and governance	**68**	No NHS trust should be given support to make an application to Monitor unless, in addition to other criteria, the performance managers is satisfied that the organisation currently meets Monitor's criteria for authorisation and that it is delivering a sustainable service which is, and will remain, safe for patients, and is compliant with at least fundamental standards. (February 2013)	This recommendation was accepted by the Government. The NHS Trust Development Authority published an accountability framework which set out the requirement that the achievement of Foundation Trust status would only be possible for trusts delivering the key fundamentals of clinical quality, good patient experience and national and local standards and targets. The trust must establish a baseline of its quality, safety and sustainability.	Hard Truths: The Journey to Putting Patients First: Volume Two e.g. 2015/16 Accountability Framework	
Improving NHS culture and governance	**69**	The assessment criteria for authorisation should include a requirement that applicants demonstrate their ability to consistently meet fundamental patient safety and quality standards at the same times as complying with the financial and corporate governance requirements of a foundation trust. (February 2013)	This recommendation was accepted by the Government. The NHS Trust Development Authority published an accountability framework which set out the requirement that the achievement of Foundation Trust status would only be possible for trusts delivering the key fundamentals of clinical quality, good patient experience and national and local standards and targets. The trust must establish baseline of its quality, safety and sustainability, as well as strong governance and leadership. This would include early quality governance review. In the January 2014 Hard Truths report, the Government said that the approval process would include comprehensive inspection by the Care Quality Commission of the quality of services delivered, as well as the quality of governance arrangements within a trust.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**70**	A duty of utmost good faith should be imposed on applicants for foundation trust status to disclose to the regulator any significant information material to the application and to ensure that any information is complete and accurate. This duty should continue	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the NHS Trust Development Authority would explicitly ask trusts if they had anything to declare in relation	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		throughout the application process, and thereafter in relation to the monitoring of compliance. (February 2013)	to their application in the final board-to-board meeting before formal consideration of approval. The Government also said that submission for foundation trust status was required to include a letter from the Trust CEO that with regard to their duty of good faith they have disclosed all relevant information. The Government also enacted an offence of false or misleading information at section 92 of the Care Act 2014	Care Act 2014	
Improving NHS culture and governance	**71**	The Secretary of State's support for an application should not be given unless he is satisfied that the proposed applicant provides a service to patients which is, at the time of his consideration, safe, effective and compliant with all relevant standards, and that in his opinion it is reasonable to conclude that the proposed applicant will continue to able to do so for the foreseeable future. In deciding whether he can be so satisfied, the Secretary of State should have regard to the required public consultation and should consult with the healthcare regulator. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that this role would be carried out by the Board of the NHS Trust Development Authority on behalf of the Secretary of State, which would not refer to Monitor any trust where there are concerns relating to compliance with any of the relevant standards now or in the future. The decision of the Board would be made with regard to the public consultation and after consulting the Care Quality Commission, NHS England and other partners. In the February 2015 Culture Change report, the Government also referred to the requirement for trusts to produce 5-year strategic plans.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**72**	The assessment for an authorisation of application for foundation trust status should include a full physical inspection of its primary clinical areas as well as all wards to determine whether it is compliant with fundamental safety and quality standards. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Care Quality Commission agreed to inspect trusts when the NHS Trust Development Authority was assessing whether to support their foundation trust application.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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Improving NHS culture and governance	**73**	The Department of Health's regular performance reviews of Monitor (and the Care Quality Commission) should include an examination of its relationship with the Department of Health and whether the appropriate degree of clarity of understanding of the scope of their respective responsibilities has been maintained. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that as part of the Department of Health's normal accountability processes, the state of the relationship between it and its arm's length bodies was kept under regular review, which included consideration of how well they were working together and what could be done to improve coordination. to normal accountability processes that the Department of Health set in place as keeping relationship between the Department of Health and its arm's length bodies under regular review.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**74**	Monitor and the Care Quality Commission should publish guidance for governors suggesting principles they expect them to follow in recognising their obligation to account to the public, and in particular in arranging communication with the public served by the foundation trust and to be informed of the public's views about the services offered. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that Monitor had published a number of guidance documents for foundation trust governors, including a revised version of its guidance on statutory duties for foundation trust governors in August 2013. This included key principles to inform how governors should represent the interests of the public, including how to communicate with them. Monitor and GovernWell also produced guidance for governors on representing the interests of members and the public and the Government referred to guidance published by Monitor in March 2014, providing a brief guide for governors.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Governors guide_ August 2013 UPDATED_NOV_13 Representing the interests of members and the public	

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Improving NHS culture and governance	**75**	The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest. They should produce an agreed published description of the role of governors and how it is planned that they perform it. Monitor and the Care Quality Commission should review these descriptions and promote what they regard as best practice. (February 2013)	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, the Government referred to the various guidance as described in relation to recommendation 74 above. However, the Government said that this did not seek to prescribe how governors should work day-to-day, which was for NHS Foundation Trust boards and governors to agree. Monitor and the Care Quality Commission would not review the descriptions agreed between them.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**76**	Arrangements must be made to ensure that governors are accountable not just to the immediate membership but to the public at large – it is important that regular and constructive contact between governors and the public is maintained. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that one of the Council of Governors under the Health and Social Care Act 2012 was to represent the interest of members of the corporation as a whole and the interest of the public. However, the Government said that no definition of how governors engage and represent the public would be provided in law, it considering such arrangements being a matter for agreement between foundation trust boards and governors. However, the Government said that examples of methods by which governors might represent the interests of the public were included in Monitor's August 2013 guidance.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**77**	Monitor and the NHS Commissioning Board should review the resources and facilities made available for the training and development of governors to enhance their independence and ability to expose	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the NHS Leadership Academy had commissioned a programme known as GovernWell, to provide training for Foundation Trust governors. The Government also referred	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		and challenge deficiencies in the quality of the foundation trust's services. (February 2013)	to Monitor surveying Foundation Trust governors to review the current levels of support available. In the February 2015 Culture Change report, the Government said that Monitor had published a revised Code of Governance which set out detailed governance requirements relating to governors, including the trust's duty to take steps to ensure governors were equipped with the skills and knowledge they needed to discharge their duties appropriately. The current Code of Governance requires governors of Foundation Trusts to receive appropriate induction on joining the council of governors and to regularly update and refresh their skills and knowledge.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex NHS England » Code of governance for NHS provider trusts	
Improving NHS culture and governance	**78**	The Care Quality Commission and Monitor should consider how best to enable governors to have access to a similar advisory facility in relation to compliance with healthcare standards as will be available for compliance issues in relation to breach of a licence, or other ready access to external assistance. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that Monitor had set up a Panel for Advising Governors, operational from May 2013, to answer questions relating to (potential) breaches of a trust's constitution, breach of licence or any other matter under chapter 5 of the National Health Service Act 2006.	Hard Truths: The Journey to Putting Patients First: Volume Two NHS England » Code of governance for NHS provider trusts	
Regulation and oversight of NHS managers	**79**	There should be a requirement that all directors of all bodies registered by the Care Quality Commission, as well as Monitor for foundation trusts, are and remain, fit and proper persons for the role. Such a test should include a requirement to	This recommendation was accepted in principle by the Government. The Government introduced a fit and proper persons test, requiring directors of providers registered with the Care Quality Commission to meet a fit and proper persons test.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying	

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		comply with a prescribed code of conduct for directors. (February 2013)		the lessons of the Francis Inquiries: Supporting Annex standards-for-members-of-nhs-boards-and-ccgs-2013 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	
Regulation and oversight of NHS managers	**80**	A finding that a person is not a fit and proper person on the grounds of serious misconduct or incompetence should be a circumstance added to the list of disqualifications in the standard terms of a foundation trust's constitution. (February 2013)	This recommendation was accepted by the Government in principle. The Government referred to the introduction of a fit and proper person test. The Government also referred to Monitor's licence conditions for providers of NHS services preventing licensees from allowing unfit persons to become or continue as governors or directors, as well as ensure contracts of service with directors contain a provision permitting summary termination in the event of a director being or becoming an unfit person. In the January 2014 Hard Truths report, the Government said that it, the Care Quality Commission, the NHS Trust Development Authority and Monitor would continue to work with NHS Employers to improve the way that existing recruitment and exit procedures operated. The	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			Government's view was that this should be the focus, rather than the constitutions of foundation trusts.		
Regulation and oversight of NHS managers	**81**	Consideration should be given to including in the criteria for fitness a minimum level of experience and/or training while giving appropriate latitude for recognition of equivalence. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that experience and training should be one of the criteria for any assessment of whether someone is a fit and proper person, and it was vital that these were assessed at the recruitment stage and during ongoing appraisal. The Government also referred to Monitor's Code of Governance as setting an expectation that care should be taken to ensure that new appointees have relevant skills and experience.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Regulation and oversight of NHS managers	**82**	Provision should be made for regulatory intervention to require the removal or suspension from office after due process of a person whom the regulator is satisfied is not or is no longer a fit and proper person, regardless of whether the trust is in significant breach of its authorisation or licence. (February 2013)	This recommendation was accepted by the Government. The Government referred to the introduction of fit and proper persons test as permitting the Care Quality Commission to require removal of director where they are found to be unfit. However, the Care Quality Commission was not given the power to bar directors nor to directly regulate individual directors. The task of acting upon the Fit and Proper Person test was left to the Trusts.	Hard Truths: The Journey to Putting Patients First: Volume Two The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	
Regulation and oversight of NHS managers	**83**	If a 'fit and proper person test' is introduced as recommended, Monitor should issue guidance on the principles on which it would exercise its power to require the removal or suspension or disqualification of directors who did not fulfil it, and	This recommendation was accepted by the Government. The Care Quality Commission provided guidance on how it would apply the fit and proper purpose test.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		the procedure it would follow to ensure due process. (February 2013)		Fit and proper persons: directors - Care Quality Commission	
Regulation and oversight of NHS managers	**84**	Where the contract of employment or appointment of an executive or non-executive director is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit and proper person to hold such a post, licensed bodies should be obliged by the terms of their licence to report the matter to Monitor, the Care Quality Commission and the NHS Trust Development Authority. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said that it would expect this to be reflected in references provided by the employer to any prospective new employer, rather than by using a regulatory intermediary as a register of concerns about a person's fitness.	Hard Truths: The Journey to Putting Patients First: Volume Two Fit and proper persons: directors - Care Quality Commission	
Regulation and oversight of NHS managers	**85**	Monitor and the Care Quality Commission should produce guidance to NHS and foundation trusts on procedures to be followed in the event of an executive or non-executive director being found to have been guilty of serious failure in the performance of his or her office, and in particular with regard to the need to have regard to the public interest in protection of patients and maintenance of confidence in the NHS and the healthcare system. (February 2013)	This recommendation was accepted by the Government. The Care Quality Commission published guidance on the application of the 'fit and proper persons' test, that test including 'service misconduct' as a ground of unfitness.	Hard Truths: The Journey to Putting Patients First: Volume Two Fit and proper persons: directors - Care Quality Commission	
Regulation and oversight of NHS managers	**86**	A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to Monitor's Code of Governance setting out an expectation that directors should have access to training	Hard Truths: The Journey to Putting Patients First: Volume Two	

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			courses and/or materials, as well as Monitor's Quality Governance framework guidance as suggesting board conduct regular self-assessment and attend training sessions covering the core elements of quality governance and continuous improvement.		
Responsibility for, and effectiveness of, regulating health care systems governance – HSE functions in health settings					
Improving patient safety	**87**	The Care Quality Commission should be given power to prosecute 1974 Act offences or a new offence containing comparable provisions should be created under which the Care Quality Commission has powers to launch a prosecution. (February 2013)	This recommendation was accepted in principle by the Government. The Care Quality Commission was not given the power to prosecute 1974 Act offences. However, the Care Quality Commission was given the power to prosecute offences under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Health and Social Care Act 2008 (Regulated Activities) Amendment Regulations 2015.	Hard Truths: The Journey to Putting Patients First: Volume Two Offences - Care Quality Commission	
Improving patient safety	**88**	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators though the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said that few patient incidents fell under the category of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations and that the Care Quality Commission would in any case be informed of these incidents through the statutory notifications that registered providers are required to make. However, information between the Health Safety Executive and the Care Quality Commission would be shared on more frequent basis.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex MOU between CQC and HSE	

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			The Government said that, at the time of the February 2015 Culture Change report, the Health and Safety Executive shared quarterly investigated Reporting of Injuries, Diseases and Dangerous Occurrences Regulations accidents, complaints and enforcement and prosecution notices data. also referred to a revised liaison agreement between the Health and Safety Executive and the Care Quality Commission. A Memorandum of Understanding was agreed between the two in December 2017.		
Improving patient safety	**89**	Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said that an initial assessment of serious untoward incidents to be carried out by the Care Quality Commission with the ability to draw on the Health and Safety Executive's expertise. By the December 2017 Memorandum of Understanding between the Health and Safety Executive and the Care Quality Commission, the two organisations agreed to notify the other as appropriate as soon as possible about information they received on incidents in the jurisdiction of that body and to share relevant intelligence and enforcement data.	Hard Truths: The Journey to Putting Patients First: Volume Two MOU between CQC and HSE	
Improving patient safety	**90**	In order to determine whether a case is so serious, either in terms of the breach of safety requirements or the consequences for any victims, that the public interest requires individuals or organisations to be brought to account for the failings, the Health and Safety Executive should obtain expert advice, as is	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Health and Safety Executive had always sought expert advice and that the Care Quality Commission would also seek appropriate specialist advice in	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		done in the field of healthcare litigation and fitness to practice proceedings. (February 2013)	investigation potential breaches of the fundamental standards.		
Enhancement of the role of supportive agencies					
Improving patient safety	**91**	The Department of Health and the NHS Commissioning Board should consider what steps are necessary to require all NHS providers, whether they not remain members of the NHS Litigation Authority scheme, to have and to comply with risk management standards at least as rigorous as those required by the NHS Litigation Authority. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said, however, that the time was right to move away from assessment against risk management standards towards an outcome focused approach. The NHS Litigation Authority risk management standards from April 2014 onwards. In the February 2015 Culture Change report, the Government referred instead to the ratings system used by the Care Quality Commission.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**92**	The financial incentives at levels below level 3 should be adjusted to maximise the motivation to reach level 3. (February 2013)	This recommendation was accepted by the Government. The Government referred to changes to pricing methodology for the Clinical Negligence Scheme for Trusts implemented in April 2013, which moved away from the system of risk management discounts. Instead, the revised pricing method rewarded organisations with fewer, less costly claims.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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Improving patient safety	**93**	The NHS Litigation Authority should introduce requirements with regard to observance of the guidance to be produced in relation to staffing levels, and require trusts to have regard to evidence-based guidance and benchmarks where these exist and to demonstrate that effective risk assessment take place when changes to the numbers or skills of staff are under consideration. It should also consider how more outcome-based standards could be designed to enhance the prospect of exploring deficiencies in risk management. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said that the time was right to move away from assessment against risk management standards towards an outcome-focused approach. NHS Litigation Authority risk management standards were discontinued from April 2014 onwards. The Government said that the NHS Litigation Authority was not in a position to introduce requirements in relation to staffing levels, skill mix, or staff-patient ratios, which were instead a matter for trusts. Nevertheless, the Government said the new pricing methodology implemented by the NHS Litigation Authority took into account staffing and activity levels across higher risk areas.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**94**	As some form of running record of the evidence reviewed must be retained on each claim in order for these reports to be produced, the NHS Litigation Authority should consider development of a relatively simple database containing the same information. (February 2013)	This recommendation was accepted by the Government. In the February 2015 Culture Change report, the Government said that the NHS Litigation Authority launched its extranet service for members in 2013-14, sharing data to help them reduce claims and improve patient and staff safety. The Government said the extranet provided members with real0time access to claims data together with learning resources.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**95**	As the interests of patient safety should prevail over the narrow litigation interest under which confidentiality or even privilege might be claimed under risk reports, consideration should also be	This recommendation was accepted by the Government. In its February 2015 Culture Change report, the Government said that the NHS Litigation Authority shared	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		given to allowing the Care Quality Commission access to these reports. (February 2013)	relevant information as part of the Care Quality Commission's inspections regime.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**96**	The NHS Litigation Authority should make more prominent in its publicity an explanation comprehensible to the general public of the limitations of its standard assessments and of the reliance which can be placed on them. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the NHS Litigation Authority had included a comprehensible explanation of the limitations of the standards and assessment process on its website.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**97**	The National Patient Safety Agency's resources need to be well protected and defined. Consideration should be given to the transfer of this valuable function to a systems regulator. (February 2013)	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths Report, the Government said that the functions of the National Patient Safety Agency had been moved to NHS England, but that it agreed that resources for this function should continue to be protected. The Government said it had considered the case for transfer of the functions of the National Patient Safety Agency to a systems regulator, but determined it was better suited within NHS England. In the February 2015 Culture Change Report, the Government said it agreed with the recommendation to concentrate and consolidate national expertise and capability or safety within a single organisation. The functions were later transferred to NHS Improvement in	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			April 2016, and then retransferred to NHS England in July 2022.		
Improving patient safety	**98**	Reporting to the National Reporting and Learning System of all significant adverse incidents not amounting to serious untoward incidents but involving harm to patients should be mandatory on the part of trusts. (February 2013)	This recommendation was accepted in principle by the Government. The Government stated that its policy was not to introduce a mandatory reporting system but instead introduce a duty of candour, with more done to promote the reporting of all patient safety incidents among healthcare professionals. The Government also said that the Care Quality Commission's new Intelligent Monitoring System assessed the pattern of incident reporting to the National Reporting and Learning System by flagging organisations which demonstrated potential under-reporting of safety incidents or poor organisational commitment to monthly reporting of incidents.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**99**	The reporting system should be developed to make more information available from this source. Such reports are likely to be more informative than the corporate version where an incidence has been properly reported, and invaluable where it has not been. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government rejected encouraging wider use of reporting routes that avoid local organisations' own reporting systems, due to the risk of important information about the incident not reaching the organisation concerned. NHS England were to consider how to make an online e-form more widely available and explore feasibility of online reports being fed back to trusts. In the February 2015 Culture Change report, the Government said that NHS England was considering the	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			importance of making incident reporting as easy and widely accessible as possible through direct reports by individuals, including staff and patients.		
Improving patient safety	**100**	Individual reports of serious incidents which have not otherwise been reported should be shared with a regulator for investigation, as the receipt of such a report may be evidence that the mandatory system has not been complied with. (February 2013)	This recommendation was accepted by the Government in principle. In the January 2014 Hard Truths report, the Government said that all serious incidents involving severe harm and death reported by individuals were routinely shared with the Care Quality Commission on a weekly basis and that the Care Quality Commission received all incident reports to National Learning and Reporting System on weekly basis, regardless of the seriousness of incident. The Government rejected the view that there should be a mandatory reporting system. In the February 2015 Culture Change report, the Government also said that the Care Quality Commission's new Intelligent Monitoring System assessed the pattern of incident reporting to the National Reporting and Learning System by flagging organisations which demonstrated potential under-reporting of safety incidents or poor organisational commitment to monthly reporting of incidents.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**101**	While it may be impracticable for the National Patient Safety Agency or its successor to have its own team of inspectors, it should be possible to organise for mutual peer review inspections or the inclusion in Patient Environment Action Team representatives from outside the organisation.	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that Patient Environment Action Team Inspections had been replaced by Patient-led Assessments of the Care Environment, being annual inspections of all NHS hospitals	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		Consideration could also be given to involvement from time to time of a representative of the Care Quality Commission. (February 2013)	covering privacy and dignity, cleanliness, food and general maintenance. Carried out by teams that include at least 50% patients or members of the public.		
Improving patient safety	**102**	Data held by the National Patient Safety Agency or its successor should be open to analysis for a particular purpose, or other facilitated in that task. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that greater sharing of National Reporting and Learning System information was a stated aim of NHS England, with NHS England said to be exploring the extent to which serious untoward incident information could be disclosed in more detail, and considering how greater access can be provided to others for the purposes of analysis of patient safety data. In the February 2015 Culture Change Report, the Government referred to the launch of NHS Choices microsite in June 2014, bringing together a range of patient safety data. The Government also said that NHS England made data on patient safety incidents available to a wide range of patient safety research, academics and improvement specialists via data sharing agreements. The Care Quality Commission was also said to have unfettered access to all patient safety incidents reported to the National Reporting and learning System.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**103**	The National Patient Safety Agency or its successor should regularly share information with Monitor.	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that NHS England were actively working with Monitor to ensure they have access to patient safety data they require and that they will be able to use it appropriately.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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			In the February 2015 Culture Change Report, the Government said that NHS England and Monitor had established data sharing arrangements of the sharing of National Reporting Learning System data, including an agreement to share this data monthly since April 2014.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**104**	The Care Quality Commission should be enabled to exploit the potential of the safety information obtained by the National Patient Safety Agency or its successor to assist it in identifying areas for focusing its attention. There needs to be a better dialogue between the two organisations as to how they can assist each other. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths Report, the Government said that NHS England and the Care Quality Commission were working together to develop a set of patient safety measures and were publishing a joint statement between them on how the two organisations would align their work. In the February 2015 Culture Change Report, the Government said that NHS England and the Care Quality Commission had worked jointly to ensure a shared view of patient safety data, which was reflected in the Care Quality Commission's new surveillance model. The Government also stated that the Care Quality Commission had free and unfettered access to all incident reporting information collected by the National Reporting and Learning System and through the Strategic Information System.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**105**	Consideration should be given to whether information from incident reports involving deaths in hospital could enhance consideration of the hospital standardised mortality ratio. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths Report, the Government said that NHS England was leading work to develop proposals for ensuring every trust undertakes retrospective case note reviews of patient deaths according to consistent methodology, to further encourage learning from adverse events.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the	

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			In the February 2015 Culture Change Report, the Government said that NHS England was exploring the development of a standardised process for supporting the NHS to undertake retrospective case note review.	Francis Inquiries: Supporting Annex	
Improving patient safety	**106**	The Health Protection Agency and its successor should coordinate the collection, analysis and publication of information on each provider's performance in relation to healthcare associated infections, working with the Health and Social Care Information Centre. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that Public Health England was working together with the Health and Social Care Information Centre to coordinate the collection, analysis and publication of information in relation to healthcare associated infections. In the February 2015 Culture Change report, the Government referred to Public Health England publishing routine mandatory surveillance data on certain infections; providing expertise to support the development of a new integrated data capture system; and providing expertise to support NHS organisations regarding positive cases of MRSA in undertaking post-infection reviews.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**107**	If the Health Protection Agency or its successor, or the relevant local director of public health or equivalent official, becomes concerned that a provider's management of healthcare associated infections is or may be inadequate to provide sufficient protection of patients or public safety, they should immediately inform all responsible commissioners, including the relevant regional office of the NHS Commissioning Board, the Care Quality Commission and, where relevant, Monitor, of those concerns. Sharing of such information	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that Public Health England was formalising the process by which it internally escalated and informed local and national commissioners and regulators about any concerns they might have about management of healthcare associated infections. Public Health England and the Care Quality Commission's April 2013 Memorandum of Understanding included	Hard Truths: The Journey to Putting Patients First: Volume Two Memorandum of Understanding between Public Health England and the Care	

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		should not be regarded as an action of last resort. It should review its procedure to ensure clarity of responsibility for taking this action. (February 2013)	provision for Public Health England to notify the Care Quality Commission where it had concerns about relevant incidents ad outbreaks, including in relation to how a service has managed to them. In the February 2015 Culture Change report, the Government said that Public Health England was undertaking work to review and revise arrangements for the sharing of information and escalation of concerns relating to the management of healthcare associated infections by healthcare providers.	Quality Commission	
Improving patient safety	**108**	Public Health England should review the support and training that health protection staff can offer to local authorities and other agencies in relation to local oversight of healthcare providers' infection control arrangements. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that Public Health England was considering options as to how it would provide this support and training. In the February 2015 Culture Change report, the Government said that Public Health England was continuing to work with partners across the Health Protection Directorate, the Nursing Directorate and the Operations Directorate to explore options to improve training.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Effective Complaints Handling					
Improving the ability to raise	**109.**	Methods of registering a comment or compliant must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion,	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said the Department of Health would discuss with	Hard Truths: The Journey to Putting Patients First: Volume Two	

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complaints and concerns		although all such methods should trigger a uniform process, generally led by the provider trust. (February 2013)	Healthwatch England, the Care Quality Commission and NHS England putting up signs in every ward and clinical setting giving information about how patients could complain to the hospital, who they could turn to for independent support, their right to go to the Ombudsman and details of how to contact their local Healthwatch. In the February 2015 Culture Change report, the Government said the Department of Health had made a complaints poster template available to the NHS at the end of November 2014; and the Parliamentary and Health Service Ombudsman had published with Healthwatch England and the Local Government Ombudsman universal expectations for raising concerns and complaints. It also stated that the Department of Health and NHS England were issuing an assessable feedback and complaints guide for patients. The Department of Health and NHS England issued a guide for patients on complaining and poster made available.	Culture change in the NHS – Applying the lessons of the Francis Inquiries Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving the ability to raise complaints and concerns	**110.**	Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the NHS Litigation Authority was clear that providing an apology and an explanation response to a concern will not affect member's indemnity cover. In some, exceptional cases, it might be appropriate put the complaint on hold.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			In the February 2015 Culture Change report, the Government said that the Department of Health had published clarification on this in March 2014.		
Improving the ability to raise complaints and concerns	**111.**	Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints, constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truth report, the Government referred to the installation of signs in every ward and clinical setting giving information about how patients can complain to the hospital, who they can turn to for independent support, their right to go to the Ombudsman and details of how to contact their local Healthwatch. The Department of Health also said it supported Healthwatch England in plans to coordinate consumer-facing complaints campaign. In the February 2015 Culture Change report, the Government said that looking at whether patients could leave feedback easily was a component of the new Care Quality Commission inspection regime.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving the ability to raise complaints and concerns	**112.**	Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said it was important that concerns and complaints are handled in accordance with the needs of the individual case.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving the ability to raise complaints and concerns	**113.**	The recommendations and standards suggested in the Patients Associations' peer review into complaints at the Mid Staffordshire NHS	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said it had asked the Parliamentary and Health Service Ombudsman and Healthwatch England develop a patient-	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		Foundation Trust should be reviewed and implemented in the NHS. (February 2013)	led vision and expectations for complaints handling in the NHS, to be used across the NHS to drive improvements in patient satisfaction with complaint handling. In November 2014, the Parliamentary and Health Service Ombudsman published a document containing universal expectations for raising concerns and complaints. The Parliamentary and Health Service Ombudsman now publishes NHS Compliant Standards, with a Summary of Expectations, a model complaint handling procedure and detailed complaint handling guidance.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex NHS Complaint Standards | Parliamentary and Health Service Ombudsman (PHSO)	
Improving the ability to raise complaints and concerns	**114.**	Comments or complaints which describe events amounting to an adverse incident or serious untoward incident should trigger an investigation. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Department of Health said it agreed that complaints amounting to serious untoward incidents warranted independent local investigation. The Government referring to NHS England's Serious Incident Framework, which set out how serious incidents should be managed, and which was published in March 2015.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Serious Incident Framework	
Improving the ability to raise complaints and concerns	**115.**	Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply: (i) A complaint amounts to an allegation of a SUI.	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, the Government said that investigation of any complaints should be	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		(ii) Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion. (iii) A complaint raises substantive issues of professional misconduct or the performance of senior managers. (iv) A complaint involves issues about the nature and extent of the services commissioned. (February 2013)	proportionate to the needs of the individual case. Investigations for less severe incidents could be undertaken by organisations themselves. The Government's view was also that there was a distinction between an independent investigation and an expert clinical opinion, with it not being appropriate for independent investigation to take place in all cases where such opinion was required.		
Improving the ability to raise complaints and concerns	**116.**	Where meetings are held between complainants and trust representatives or investigators as part of the complaints progress, advocates and advice should be readily available to all complainants who wants those forms of support. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government stated that it considered the recommendations to be best practice for local authority advocacy services. The Government said that Patient Advice and Liaison Services within trusts were to be aware of the NHS complaints advocacy providers within their areas and should publicise these arrangements. In the February 2015 Culture Change report, the Government said that the Department of Health would consider different aspects of Patient Advice and Liaison Services and identify any areas where substantial work might be commission ed to gain a better understanding.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving the ability to raise complaints and concerns	**117.**	A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases. (February 2013)	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, as complaints advocacy services had been the responsibility of local	Hard Truths: The Journey to Putting Patients First: Volume Two	

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			authorities since April 2013, the Government considered this was a matter for local authorities. The Government expressed its view that the need for expert clinical advice ought not to be determined by how complicated a case might be, but whether it was appropriate in the individual case. In the February 2015 Culture Change report, the Government said that the Department of Health would consider different aspects of Patient Advice and Liaison Services and identify any areas where substantial work might be commission ed to gain a better understanding.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving the ability to raise complaints and concerns	**118.**	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically-related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission. (February 2013)	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, the Government said it wished to reconsider the recommendation in relation to complaints of a serious nature and making them available in a wider range of formats, once an agreed and consistent standard existed against which to judge the handling of an individual complaint. The February 2015 Culture Change report did not explicitly address this planned reconsideration.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving the ability to raise complaints and concerns	**119.**	Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance of the requirement of patient confidentiality. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said it agreed that local Healthwatch organisations should have access to detailed information about complaints. The Government said that the Department of Health would also work with the Health and Social Care Information Centre to	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying	

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			put complaints data into existing NHS electronic data collection systems.	the lessons of the Francis Inquiries: Supporting Annex	
Improving the ability to raise complaints and concerns	**120.**	Commissioners should require access to all complaints as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by the NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so. (February 2013)	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, the Government said that requiring trusts to provide all complaints information would place significant bureaucratic burden on both the provider and the commissioning body. The Department of Health would instead ensure that each quarter every hospital published information on the complaints it received. In the February 2015 Culture Change report, the Government said that the Department of Health was working with the Health and Social Care Information Centre to develop a system that enabled trusts to published detailed quarterly data on the number of complaints received, with revised reports expected by late summer 2015.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving the ability to raise complaints and concerns	**121.**	The Care Quality Commission should have a means of ready access to information about the most serious complaints. Their local inspectors should be charged with informing themselves of such complaints and the detail underlying them. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said the Care Quality Commission would review how it makes best use of complaints and what information on complaints it should require from providers. In the February 2015 Culture Change report, the Government said that Quality Surveillance Groups had	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the	

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			been established to identify risks to quality at an early stage by actively sharing information and intelligence.	Francis Inquiries: Supporting Annex	
Improving the ability to raise complaints and concerns	**122.**	Large-scale failures of clinical service are likely to have in common a need for: (i) Provision of prompt advice, counselling and support to very distressed and anxious members of the public. (ii) Swift identification of persons of independence, authority and expertise to lead investigations and reviews. (iii) A procedure for the recruitment clinical and other experts to review cases. (iv) A communications strategy to inform and reassure the public of the processes being adopted. (v) Clear lines of responsibility and accountability for the setting up and oversight of such reviews. Primary responsibility should reside in the National Quality Board. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the government rejected that the recommendation should be a function of the National Quality Board. Instead, the Government considered this to be a matter for existing regulators and providers, as appropriate, to ensure that all those directly involved in the identified failure work together though the single failure regime. In the February 2015 Culture Change report, the Government said that inadequate care was now addressed by the Care Quality Commission's ability to place a trust in special measures, with Monitor and the NHS Trust Development Authority typically undertaking a number of interventions to improve performance and require the trust to publish progress against an action plan every month, with re-inspection by the Care Quality Commission after 12 months.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Commissioning for Standards					
Improving NHS culture and governance	**123.**	GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services. They should be an independent, professionally qualified check on the quality of service, in particular in relation to an assessment of outcomes. They need to have internal systems enabling them to be aware of	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that NHS England was developing relevant guidance and tools for clinical commissioning groups to monitor the quality of service provision and support continuous improvement.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		patterns of concern, so that they do not merely treat each case on its individual merits. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice reality. (February 2013)	NHS England and clinical commissioning groups developed a framework for commissioning for quality, published in July 2014. The Government referred to Quality Surveillance Groups, within which clinical commissioning groups could share information and intelligence with other parts of the local system. The Government also referred to the various other mechanisms through which GPs could report concerns about services.		
Improving NHS culture and governance	**124.**	The commissioner is entitled to and should, wherever it is possible to do so, apply a fundamental safety and quality standard in respect of each item of service it is commissioning. In relation to each such standard, it should agree a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance by requiring redress for individual patients who have received sub-standard service to be offered by the provider. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said that commissioners would only contract providers that are meeting fundamental standards, and commissioners were to have regard to any fundamental standard that related to a service they commission, with the NHS Standard Contract allowing for agreement at a local level for the method of measuring compliance with such standards and any appropriate sanctions. The Government said it had considered whether commissioners should incentivise compliance through redress for individual patients, but decided not to after consultation.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**125.**	Commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards. They can incentivise such	This recommendation was accepted by the Government. In the January 2014 Hard Truths Report, the Government referred to the NHS Standard Contract as allowing for	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		improvements either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work. (February 2013)	agreement on a range of quality standards or development towards higher standards. The Government also said that NHS England would set and incentivise enhanced standards through evidence-based indicators for improvement, against which it and clinical commissioning groups could set improvement trajectories. NHS England would make funding available to commissioners to use in setting local improvement goals.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**126.**	The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners and guidance for commissioners on which they should expect to see in any organisational transitions amongst their providers. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the handover process from strategic health authorities and primary care trusts to the reformed NHS system was developed with guidance on effective quality handover form the National Quality Board, which would be used as a template for future transitions. The Government said that NHS England to consider what further support and guidance might be required. No update was given in the February 2015 Culture Change report.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**127.**	The NHS Commissioning Board and local commissioners must be provided with the infrastructure and support to enable a proper scrutiny of its providers' services based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the NHS Standard Contract, NHS England's assurance of clinical commissioning groups and the development of commissioning support services provided an infrastructure to ensure that commissioners had the capacity and capability to scrutinise providers' services.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			In the February 2015 Culture Change report, the Government said the NHS Standard Contract continued to provide this framework, with revised provisions relating to commissioner's rights to suspend the provision of services being included in the NHS Standard Contract for 2014-15.		
Improving NHS culture and governance	**128.**	Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement expertise. When groups are too small to acquire such support, they should collaborate with others to do so. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that commissioning support had as being developed to provide commissioners with the range of capacity and expertise needed to commission effectively. In the February 2015 Hard Truths report, the Government said that NHS England had introduced a Lead Provider Framework agreement for commissioning support services, to ensure that clinical commissioning groups and other commissioners had a choice of commissioning support suppliers.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**129.**	In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed. (February 2013)	This recommendation was accepted by the Government. The Government referred to National Commissioning for Quality and Innovation Guidance by NHS England, setting out steps for commissioners to assure themselves that services being commissioned are safe and clinically effective, published in July 2014.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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Improving NHS culture and governance	**130.**	Commissioners – not providers – should decide what they want to be provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers and from elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said it agreed that it was for commissioners to determine what must be provided. The Government said there was a range of mechanisms for providers and their clinicians to offer advice and proposals to commissioners, such as Strategic Clinical Networks and Clinical Senates.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**131.**	Commissioners need, wherever possible, to identify and make available alternative sources of provision. This may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with providers. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that NHS England supported commissioning being undertaken collaboratively, where appropriate. In the February 2015 Culture Change report, the Government said that NHS was supporting commissioners to explore new models of commissioning, with plans to work with clinical commissioning groups on the development of new models for the co-commissioning for primary care; plans to pool funding for key groups across local authorities, clinical commissioning groups and specialised commissioning from April 2015; and the announcement of a taskforce to analyse current specialised commissioning arrangements.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**132.**	Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period: (i) Such monitoring may include requiring quality information generated by the provider.	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that commissioning support services existed to provide this resource and expertise regarding monitoring of quality	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		(ii) Commissioners must also have the capacity to undertake their own (or independent) audits, inspections and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases. (iii) The possession of accurate, relevant and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulations. (iv) Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving the healthcare regulator to focus on fundamental standards. (February 2013)	information, including compliance with fundamental and enhanced standards and undertaking audits. In the February 2015 Culture Change report, the Government said that NHS England was introducing a Lead Provider Framework agreement for commissioning support services to ensure that clinical commissioning groups and other commissioners had a choice of commissioning support suppliers. The Government further referred to NHS England's framework for commissioning for quality, published in July 2014.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**133.**	Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patients where it appears to them it is not being dealt with satisfactorily, while respecting the principles that it is the provider who has primary responsibility to process and respond to complaints about its services. (February 2013)	This recommendation was accepted by the Government in principle. The Government said that, while in complaints of a serious nature, commissioners would want to be aware and take action where they believe da provider was in breach of their contract with regard to patient safety and service quality, complaints were best dealt with by the local organisations. The Government said it was concerned that the	Hard Truths: The Journey to Putting Patients First: Volume Two	

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			recommendation risked uncertainty over roles and responsibilities in the management of complaints if commissioning bodies could intervene in the management of an individual complaint.		
Improving NHS culture and governance	**134**	Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers. (February 2013)	This recommendation was accepted by the Government. Local Authorities were given responsibility for commissioning NHS complaints advocacy under the Health and Social Care Act 2012.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**135.**	Commissioners should be accountable to their public for the scope and quality of services they commission. Acting on behalf of the public requires their full involvement and engagement: (i) There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners. (ii) There should be a lay commissioner's board. (iii) Commissioners should create and consult with patient forums and local representative groups. Individual members of the public must have access to a consultative process so their views can be taken into account. (iv) There should be regular surveys of patients and the public more generally.	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, the Government referred to the implementation of a new role for lay members on clinical commissioning group governing bodies. The Government said, however, that there were a range of mechanisms for involving the public in commissioning decisions without requiring the development of new 'membership' models. The Government also referred to a duty of public involvement on clinical commissioning group. The Government said NHS England published guidance on clinical commissioning groups and public participation in September 2013. The Government further referred to there being regular national and local patient and public surveys as well as the NHS friends and family tests. As to transparency, the Government said that the constitutions of clinical commissioning groups were required to specify the arrangements made for securing that there was	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex NHS-England-participation-and-inclusion-guidance-2013	

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		(v) Decision-making processes should be transparent: decision-making bodies should hold public meetings. (February 2013)	transparency about the decisions of the group and the manner in which they were made. In the February 2015 Culture Change report, the Government said that a Citizens Assembly had been launched in March 2014.		
Improving NHS culture and governance	**136.**	Commissioners need to be recognisable public bodies, visibly acting on behalf of the public they serve and with a sufficient infrastructure of technical support. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that NHS England would support and assure clinical commissioning groups to be recognisable, visible local bodies. The Government said that clinical commissioning groups did this in a number of ways, including by publishing their constitution, appointing independent lay members, holding meetings in public, and presenting its annual report and annual accounts.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**137.**	Commissioners should have powers of intervention where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from the risk of harm. In the provision of the commissioned services, such power should be aligned with similar powers of the regulator so that both commissioners and regulators can act jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop provision of a service. (February 2013)	This recommendation was not accepted by the Government. In the January 2014 Hard Truths report, the Government said that the respective roles of commissioners and regulators in their relationships with providers were different and had to be distinct. While the NHS Standard Contract enabled commissioners to intervene where substandard or unsafe services were being provided, and in extreme circumstances suspend services, enforcement action was properly the role of the regulator. If commissioners have concerns about whether providers are meeting the essential standards of quality and safety, Quality Surveillance Groups would be one of the mechanisms	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			through which they could raise concerns with the Care Quality Commission. In the February 2015 Culture Change report, the Government said that revised provisions relating to commissioners' rights to suspend the provision of services were included in the NHS Standard Contract for 2014-15.		
Local scrutiny					
Improving patient safety	**138.**	Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found that they are at risk from substandard or unsafe services. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that NHS England was support commissioners in developing plans for responding to serious provider failure. In the February 2015 Culture Change report, the Government said that many commissioners had developed plans for responding to a serious provider failure, with all clinical commissioning groups	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Performance management and strategic oversight					
Improving patient safety	**139.**	The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that registration by the Care Quality Commission and Monitor's licensing of providers would give assurance to commissioners that a provider meets fundamental standards of care. Further, the NHS Standard Contract would provide a framework for commissioners to receive ongoing assurance on compliance with standards.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			In the February 2015 Culture Change report, the Government said that further assurance would be given by the Care Quality Commission's new inspection regime.		
Improving patient safety	**140.**	Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible all relevant information with the relevant regulator, including information about its judgment as the safety of patients of the healthcare provider. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to Quality Surveillance Groups and risk summits processes as providing the framework for this, as well as memoranda of understanding and operational protocols between specific organisations. In the February 2015 Culture Change report, the Government said that a review of the Quality Surveillance Group model had been undertake by all of the organisations represented on the National Quality Board and on Quality Surveillance Groups.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**141.**	Any differences of judgment as to immediate safety concerns between a performance manager and a regulator should be discussed between them and resolved where possible, but each should recognise its retained individual responsibility to take whatever action within its power is necessary in the interests of patient safety. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said that commissioners and regulators should have clear and distinct roles. The Government referred to commissioners' ability to share information and discuss safety concerns with regulators, as well as intervene under the NHS Standard Contract where substandard or unsafe services are being provided. The Care Quality Commission was to retain its ability to stop a service from providing care, impose conditions on a provider's registration or suspend it.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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Improving NHS culture and governance	**142.**	For an organisation to be effective in performance management, there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that providers were accountable to commissioners for the quality of the services they deliver, with clarify on information flows set out in the NHS Standard Contract.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**143.**	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that a range of metric were published across the health sector relating directly to the quality of patient care, including data on infection control, safety incidents, Hospital-level Mortality Indicator and patients' feedback. The Government referred to the publication by the Health and Social Care Information Centre, of could information and statistics which can be used across the health and care system to review performance and identify concerns. In the February 2015 Culture Change report, the Government said that NHS Choices had been publishing more in-depth and detailed information about the safety of hospitals since June 2014.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**144.**	The NHS Commissioning Board should ensure the development of metrics on quality and outcomes of care for use by commissioners in managing the performance of providers, and retain oversight of these through its regional offices, if appropriate. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the NHS Outcomes Framework, contained in a range of indicators which provided national overview of how well the NHS was performing. The Government said that NHS England planned to widen a programme of publishing specialities level data on NHS Choices.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the	

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			In the February 2015 Culture Change report, the Government referred to the Clinical Commissioning Group Outcomes Indicator Set, which it said provided clear, comparative information for clinical commissioning groups, Health and Wellbeing Board, local authorities and patients and the public about the quality of health services. The Government said that NHS England planned to publish consultant-level outcomes data from all appropriate NHS-funded national clinical audits before 2020. .	Francis Inquiries: Supporting Annex	
Patient, public and local scrutiny					
Improving patient safety	**145.**	There should be a consistent basic structure for Local Healthwatch throughout the country.	This recommendation was not accepted by the Government. In the January 2014 Hard Truths report. the Government said that local Healthwatch organisations should be set up in a way that best meets the needs and reflects the circumstances of local communities, with no requirement for consistency of form. However, the Government stated that Healthwatch England would provide support and leadership to local Healthwatch organisations.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**146.**	Local authorities should be required to pass over the centrally provided funds allocated to its Local Healthwatch, while requiring the latter to account for its stewardship of the money. Transparent respect for the independence of Local Healthwatch should not be allowed to inhibit a responsible local authority – or Healthwatch England as appropriate – intervening. (February 2013)	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, the Government said it did not accept that local authorities should be required to pass over centrally provided funds, instead leaving such decisions to local authorities. However, the Government said it would require each local Healthwatch to set out the amount of funding it receives in its annual report, to ensure transparency. The Government accepted	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			that local Healthwatch should account to its local authority for its use of funding. In the February 2015 Culture Change report, the Government said that Healthwatch England had published information on local authority spend for the last two financial years, and that Local Healthwatch was required to include in their annual reports the funding they had received from their commissioning local authority.		
Improving patient safety	**147.**	Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Department of Health said it was working with partners to develop this guidance. In the February 2015 Culture Change report, the Government said that guidance had been issued to local authorities on how to scrutinise local health systems in June 2014.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**148.**	The complexities of the health service are such that proper training must be available to the leadership of Local Healthwatch as well as expert advice. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that Healthwatch England was working to support local Healthwatch in their identification and analysis of issues, with training and support made available through Healthwatch England. On expert advice, the Government said that local Healthwatch organisations had the flexibility to source such advice as they require.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			In the February 2015 Hard Truths report, the Government said that Healthwatch England continued to provide training and support to local Healthwatch.		
Improving patient safety	**149.**	Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Department of Health said it was working with partners to develop this guidance. In the February 2015 Culture Change report, the Government said that guidance had been issued to local authorities on how to scrutinise local health systems in June 2014. The Government also dais that the Department of Health was delivering programmes to increase the availability and transparency of data for local authorities.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**150.**	Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structure to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said that local authority scrutiny functions ha legal powers to require providers of NHS services to provide information and to attend scrutiny meetings, while local Healthwatch had the power to enter and view certain premises. The Government said that giving further powers to local authorities would be duplicative, potentially burdensome and possibly creating confusion over rules and responsibilities.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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Improving patient safety	**151.**	MPs are advised to consider adopting some simple system for identifying trends in the complaints and information they received from constituents. They should also consider whether individual complaints imply concerns of wider significance than the impact on one individual patient. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said it was not for it to advise individual MPs on the systems they employed to identify the wider significance of individual complaints about health and care services. The Government did, however, say that MPs could share correspondence with regulators with informed consent.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Medical training and education					
Improving patient safety	**152.**	Any organisation which in the course of review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns. (February 2013)	This recommendation was accepted by the Government as well as by the General Medical Council in its spring 2013 initial response. In the January 2014 Hard Truths report, the Government said that memoranda of understanding and protocols for sharing information existed between the Care Quality Commission and Health Education England, the General Medical Council and the Nursing a Midwifery Councill. The Government also referred to Health Education England's membership of regional Quality Surveillance Groups. A Memorandum of Understanding between Health Education England and the Care Quality Commission memorandum of understanding (publicly available version dated May 2016) included information sharing provisions between the two organisations. The joint operational protocol between General Medical Council and the Care Quality Commission (publicly	Hard Truths: The Journey to Putting Patients First: Volume Two MOU between CQC and HEE The General Medical Council response to the report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry. CQC and GMC Joint Operational Protocol (2020)	

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			available version dated June 2020) contained information sharing provisions, including any concerns the General Medical Council has about training. The joint working protocol between the Nursing and Midwifery Council and the Care Quality Commission (publicly available version dated November 2017) contained information sharing provisions, including any concerns the Nursing and Midwifery Council had about training at an organisation.	Updated Joint Working Protocol - CQC and NMC (November 2017)	
Improving patient safety	**153.**	The Secretary of State should by statutory instrument specify all medical education and training regulator as relevant bodies for the purpose of their statutory duty to cooperate. Information sharing between the deanery, commissioners, the General Medical Council, the Care Quality Commission and Monitor with regard to patient safety issues must be reviewed to ensure that each organisation is made aware of matters of concern relevant to their responsibilities. (February 2013)	This recommendation was accepted in principle by the Government and accepted by the General Medical Council in its spring 2013 initial response. Duties to cooperate are found in sections 288 to 290 Health and Social Care Act 2012. Health Education England was added to the list of relevant bodies on 1 April 2015. No other medical education and training regulators were added to the list. In its January 2014 Hard Truths report, the Government referred to the various operational protocol and memoranda of understanding between relevant organisations. The Government also said that information from The General Medical Council and Royal Colleges was potential trigger for regulatory intervention in Monitor's Risk Assessment Framework. A Memorandum of Understanding between Health Education England and the Care Quality Commission memorandum of understanding (publicly available version	Hard Truths: The Journey to Putting Patients First: Volume Two Health and Social Care Act 2012 MOU between CQC and HEE The General Medical Council response to the report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry.	

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			dated May 2016) included information sharing provisions between the two organisations. The joint operational protocol between General Medical Council and the Care Quality Commission (publicly available version dated June 2020) contained information sharing provisions, including any concerns the General Medical Council has about training. The joint working protocol between the Nursing and Midwifery Council and the Care Quality Commission (publicly available version dated November 2017) contained information sharing provisions, including any concerns the Nursing and Midwifery Council had about training at an organisation.	CQC and GMC Joint Operational Protocol (2020) Updated Joint Working Protocol - CQC and NMC (November 2017)	
Improving patient safety	**154.**	The Care Quality Commission and Monitor should develop practices and procedures with training regulators and bodies responsible for the commissioning and oversight of medical training to coordinate their oversight of healthcare organisations which provide regulated training. (February 2013)	This recommendation was accepted by the Government. In its January 2014 Hard Truths report, the Government referred to joint operational protocols between the General Medical Council and the Care Quality Commission and between the Nursing and Midwifery Council and the Care Quality Commission. The Government also referred to efforts to agree operational protocols between the Care Quality Commission and the Healthcare Professions Council. A Memorandum of Understanding between the Care Quality Commission and the Healthcare Professions Council was entered into in September 2014.	Hard Truths: The Journey to Putting Patients First: Volume Two CQC and GMC Joint Operational Protocol (2020) Updated Joint Working Protocol - CQC and NMC (November 2017) CQC HCPC MoU	

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Improving patient safety	**155.**	The General Medical Council should set out a standard requirement for routine visits to each local education provider and programme in accordance with the following principles: (i) The Postgraduate Dean should be responsible for managing the process at the level of the Local Educational Training Board, as part of overall deanery functions. (ii) The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required. (iii) There should be lay or patient representation on visits to ensure that patient interests are maintained as the priority. (iv) Such visits should be informed by all other sources of information and, if relevant, coordinated with the work of the Care Quality Commission and other forms of review. The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out. All healthcare organisations must be required to release healthcare professionals to support the visits programme. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the evidence pack supporting General Medical Council inspection teams contained information from the Care Quality Commission and other external organisations. The General Medical Council expressed its commitment on a through and consistent inspection regime. The General Medical Council's final October 2014 update report accepted the recommendation at (ii). It is unclear from the final update report whether the other recommendations were accepted. In the February 2015 Culture Change report, the Government said that the General Medical Council had begun scoping work to address this recommendation.	Hard Truths: The Journey to Putting Patients First: Volume Two October 2014 update on the GMC's work to address the Francis Recommendations Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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Improving patient safety	**156.**	The system for approving and accrediting training placement providers and programmes should be configured to apply the principles set out above. (February 2013)	This recommendation was accepted by the Government. The General Medical Council published a new standards framework in July 2015, which came into effect in January 2016.	Hard Truths: The Journey to Putting Patients First: Volume Two Promoting excellence: standards for medical education and training	
Improving patient safety	**157.**	The General Medical Council should set out a clear statement of what matters deaneries are required to report to it either routinely or as they arise. Reports should include a description of all relevant activity and findings and not be limited to exceptional matters of perceived non-compliance with standards. Without a compelling and recorded reason, no professional in a training organisation interviewed by a regulator in the course of an investigation should be bound by a requirement of confidentiality not to report the existence of an investigation, and the concerns raised by or to the investigation within his own organisation. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the General Medical Council already had a structured reporting template supported by guidance setting out what deans were required to report to the General Medical Council In the February 2015 Culture Change report, the Government stated that the General Medical Council continued to work with deans to improve reporting mechanisms.	Hard Truths: The Journey to Putting Patients First: Volume Two October 2014 update on the GMC's work to address the Francis Recommendations Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**158.**	The General Medical Council should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of	This recommendation was accepted by the Government. The General Medical Council published new standards in July 2015, which came into effect in January 2016. These included a requirement that "*Organisations must*	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		patient safety and quality of care, and should generally place the highest priority on the safety of patients. (February 2013)	*demonstrate a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care…*"	Promoting excellence: standards for medical education and training	
Improving patient safety	**159.**	Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provided to patients. The General Medical Council should consult the Care Quality Commission in developing the survey and routinely share information obtained with healthcare regulators. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the General Medical Council was now including questions about quality of care provided to patients in the National Training Survey, and that the General Medical Council was also surveying students ahead of formal visits to their medical schools. The General Medical Council's National Training Survey was amended to include more information for participants about how concerns raised in their responses to the survey would be addressed and how that information would allow local providers to identify patient safety problems that may not have been provided.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**160.**	Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the General Medical Council was running professionalism events at all medical schools every year. The Government also referred to the establishment of confidential helpline for doctors and the inclusion of a patient safety question in National Training Survey. In the February 2015 Culture Change report, the Government said that the encouragement of openness in	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			trainees and protecting them from the potential adverse consequences of raising a concern was included in the 2014 Health Education England mandate. The General Medical Council published new standards for medical education and training in July 2015, which came into effect in January 2016. These included a requirement that "*Organisations […] demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences.*"	Promoting excellence: standards for medical education and training	
Improving patient safety	**161.**	Training visits should make an important contribution to the protection of patients: (i) Obtaining information directly from trainees should remain a valuable source of information, but not only the method used. (ii) Visits to, and observation of, the actual training environment would enable visitors to detect poor practice from which both patients and trainees should be sheltered. (iii) The opportunity can be taken to share and disseminate good practice with trainers and management. (February 2013)	This recommendation was accepted by the Government. At the end of March 2014, the General Medical Council began publishing information about validated education concerns subject to enhanced monitoring by the General Medical Council. The General Medical Council introduced a document register section at the end of each visit report to detail what evidence has been used and how it has contributed to findings; developed 5-year visits schedule; and decided to pilot General Medical Council inspection teams to observe the environment in which clinical teaching occurs.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex October 2014 update on the GMC's work to address the Francis Recommendations	

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Improving patient safety	**162.**	The General Medical Council should in the course of its review of its standards and regulatory process ensure that the system of medical training and education maintains as its first priority the safety of patients. It should also ensure that providers of clinical placements are unable to take on students or trainees in areas which do not comply with fundamental patient safety and quality standards. Regulators and deaneries should exercise their own independent judgement as to whether such standards have been achieved and if at any stage concerns relating to patient safety are raised to the, must take appropriate action to ensure these concerns are properly addressed. (February 2013)	This recommendation was accepted by the Government. In its February 2015 Culture Change report, the Government said that the General Medical Council, the Medical Schools Council, Foundation Programme and Royal Colleges were working to ensure that medical students and doctors in training were to become patient safety champions. The General Medical Council published new standards for medical education and training in July 2015, which came into effect in January 2016. They begin by stating that "*Patient safety is at the core of these standards."*	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Promoting excellence: standards for medical education and training	
Improving patient safety	**163.**	The General Medical Council's system of reviewing the acceptability of the provision of training by healthcare providers must include a review of the sufficiency of the numbers and skills of available staff for the provision of training and to ensure patient safety in the course of training. (February 2013)	This recommendation was accepted by the Government. The General Medical Council published new standards for medical education and training in July 2015, which came into effect in January 2016. R.6 provided "*Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard."*	Hard Truths: The Journey to Putting Patients First: Volume Two Promoting excellence: standards for medical education and training	
Improving patient safety	**164.**	The Department of Health and the General Medical Council should review whether the resources available for regulating Approved Practice Setting	This recommendation was accepted by the Government in principle. The General Medical Council undertook a review of the Approved Practice Setting scheme in 2013. The review	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		are adequate and, if not, make arrangements for the provision of the same. (February 2013)	concluded that it should be replaced by a new scheme which was aligned with the existing statutory duties for healthcare organisations, namely the Responsible officer Regulations. This prevented newly registered or recently restored doctors from practicing in circumstances where they did not have a 'prescribed connection to a designated body'. The new Approved Practice Setting requirements were introduced in June 2014.	October 2014 update on the GMC's work to address the Francis Recommendations	
Improving patient safety	**165.**	The General Medical Council should immediately review its approved practice settings criteria with a view to recognition of the priority to be given to protecting patients and the public. (February 2013)	This recommendation was accepted by the Government in principle. The General Medical Council undertook a review of the Approved Practice Setting scheme in 2013. The review concluded that it should be replaced by a new scheme which was aligned with the existing statutory duties for healthcare organisations, namely the Responsible officer Regulations. This prevented newly registered or recently restored doctors from practicing in circumstances where they did not have a 'prescribed connection to a designated body'. The new Approved Practice Setting requirements were introduced in June 2014.	Hard Truths: The Journey to Putting Patients First: Volume Two October 2014 update on the GMC's work to address the Francis Recommendations	
Improving patient safety	**166.**	The General Medical Council should in consultation with patient interest groups and the public immediately review its procedures for assuring compliance with its approved practice settings criteria with a view in particular to provision for active exchange of relevant information with the healthcare systems regulator, coordination of monitoring processes with others required for medical education and training, and receipt of relevant information from registered practitioners of	This recommendation was accepted by the Government in principle. The General Medical Council undertook a review of the Approved Practice Setting scheme in 2013. The review concluded that it should be replaced by a new scheme which was aligned with the existing statutory duties for healthcare organisations, namely the Responsible officer Regulations. This prevented newly registered or recently restored doctors from practicing in circumstances where	Hard Truths: The Journey to Putting Patients First: Volume Two October 2014 update on the GMC's work to address the Francis Recommendations	

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		their current experience in approved practice settings approved establishments. (February 2013)	they did not have a 'prescribed connection to a designated body'. The new Approved Practice Setting requirements were introduced in June 2014.		
Improving patient safety	**167.**	The Department of Health and the General Medical Council should review the powers available to the General Medical Council in support of assessment and monitoring of approved practice settings establishments with a view to ensuring that the General Medical Council (or if considered to be more appropriate, the healthcare systems regulator) has the power to inspect establishments, either itself or by an appointed entity on its behalf, and to require the production of relevant information. (February 2013)	Accepted by the Government in principle. The General Medical Council undertook a review of the Approved Practice Setting scheme in 2013. The review concluded that it should be replaced by a new scheme which was aligned with the existing statutory duties for healthcare organisations, namely the Responsible officer Regulations. This prevented newly registered or recently restored doctors from practicing in circumstances where they did not have a 'prescribed connection to a designated body'. The new Approved Practice Setting requirements were introduced in June 2014. In the February 2015 Culture Change report, the Government referred to the role of the Care Quality Commission in the overall assurance of levels of safety and quality of healthcare services, it already having powers to enter and inspect premises.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex October 2014 update on the GMC's work to address the Francis Recommendations	
Improving patient safety	**168.**	The Department of Health and the General Medical Council should consider making the necessary statutory (and regulatory changes) to incorporate the approved practice settings schemes into the regulatory framework for post graduate training. (February 2013)	This recommendation was accepted by the Government in principle. The General Medical Council undertook a review of the Approved Practice Setting scheme in 2013. The review concluded that it should be replaced by a new scheme which was aligned with the existing statutory duties for healthcare organisations, namely the Responsible officer Regulations. This prevented newly registered or recently restored doctors from practicing in circumstances where	Hard Truths: The Journey to Putting Patients First: Volume Two October 2014 update on the GMC's work to address the Francis Recommendations	

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			they did not have a 'prescribed connection to a designated body'. The new Approved Practice Setting requirements were introduced in June 2014.		
Improving patient safety	**169.**	The Department of Health, through the National Quality Board, should ensure that procedures are put in place for facilitating the identification of patient safety issues by training regulators and cooperation between them for healthcare systems regulators. (February 2013)	This recommendation was accepted by the Government in principle. In the January 2014 Hard Truths Report, the Government referred to the participation of the Nursing and Midwifery Council and the General Medical Council in the National Quality Board and regional quality surveillance groups, allowing them to share information and intelligence with other partners. The Government said that the General Medical Council had made it clear it recognised the need to contribute to the identification and in some cases the investigation of generic concerns, including by signposting complaints to appropriate regulators, making referrals to systems or other professional regulators and investigating concerns arising from the media. The Government said the Nursing and Midwifery Council had made it clear they were determined to work with other regulators, and that it should not have to wait until disaster before intervening with fitness to practise procedures. In the February 2015 Culture Change report, the Government said the General Medical Council had established an internal Patient Safety Intelligence Forum to coordinate information that may demonstrate concerns about patient safety, and that it had been strengthening its relationship with the Care Quality Commission.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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Improving patient safety	**170.**	Health Education England should have a medically qualified director of medical education and a lay patient representative on its board. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that Health Education England employed a medically qualified Director of Education and Quality, who took up the post in April 2013. The Government also said that Health Education England had Non-Executive Director whose role had specific focus on the interests of patients and service users and chaired the national patient forum, taking up the post on 1 September 2013. There was no mention in the Government's response of a lay patient representative.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**171.**	All Local Education and Training Boards should have a post of medically qualified postgraduate dean responsible for all aspects of postgraduate medical education. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that all Local Education and Training Boards had qualified postgraduate dean responsible for postgraduate medical education and training.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**172.**	The Government should consider urgently the introduction of a common requirement of proficiency in communication in the English language with patients and other persons providing healthcare to the standard required for a registered medical practitioner to assume professional responsibility for medical treatment of an English-speaking patient. (February 2013)	This recommendation was accepted by the Government. The Medical Act 1983 (Amendment) (Knowledge of English) Order 2014 introduced requirement to provide evidence of English language proficiency in relation to doctors from other European countries where concerns about language had been identified during the registration process (this was already a requirement in respect of other overseas doctors). It is unclear what action, if any, was taken in respect of other healthcare workers.	Hard Truths: The Journey to Putting Patients First: Volume Two October 2014 update on the GMC's work to address the Francis Recommendations	

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				The Medical Act 1983 (Amendment) (Knowledge of English) Order 2014	
Openness, transparency and candour					
Improving NHS culture and governance	**173.**	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that leaders of health and social care organisations singing up to a Statement of Common Purpose to his effect. The Government also referred to the NHS Constitution as emphasising the importance of honesty and openness, and openness and honesty already being a requirement in healthcare professionals' codes of practice. In the February 2015 Culture Change report, the government referred to the Care Quality Commission's new inspection regime, which include rating hospitals' quality of care in bands from outstanding to inadequate. The Government also referred to the availability of patient safety information on NHS choices and the introduction of the statutory duty of candour from November 2014.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**174.**	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Secretary of State for Health had required NHS England to insert a contractual duty of candour into the NHS Standard Contract in 2013-14.	The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	

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		of support, whether or not the patient or representative has asked for this information. (February 2013)	Reg. 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 imposed a duty of candour on health service bodies, which duty became a requirement for registration with the Care Quality Commission.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**175.**	Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased) to any lawfully entitled personal representative). (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that all regulated professions, through their codes of conduct, were required to be open and transparent with patients in respect of discussions and treatment and care. In the February 2015 Culture Change report, the government said that 8 UK professional healthcare regulators had published a joint statement in October 2014, which set out a professional duty of candour and clarified what the regulators expected from health professionals. In 2015, the General Medical Council and the Nursing and Midwifery Council published joint duty of candour guidance.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex NMC and GMC refresh duty of candour guidance - The Nursing and Midwifery Council	
Improving NHS culture and governance	**176.**	Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the NHS Standard Contract included a requirement of good faith. The Government created the offence of supplying, publishing or otherwise making available false or misleading information in section 92 of the Care Act 2014.	Hard Truths: The Journey to Putting Patients First: Volume Two Care Act 2014	

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Improving NHS culture and governance	**177.**	Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Guidance referred to the NHS Leadership Academy's 2013 guide as requiring the board of a healthcare organisation to ensure that published figures on all aspects of the quality of care were accurate and to provide an honest and fair account to commissioners, regulators, patients and the public. The Government created the offence of supplying, publishing or otherwise making available false or misleading information in section 92 of the Care Act 2014.	Hard Truths: The Journey to Putting Patients First: Volume Two NHSLeadership-HealthyNHSBoard-2013 (leadershipacademy.nhs.uk) Care Act 2014	
Improving NHS culture and governance	**178.**	The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said wording was included in the March 2013 update of the NHS Constitution to reflect the duty of candour. However, the Government said that the NHS Constitution was not intended to address organisational processes and interactions with regulatory bodies, so it was not appropriate to reflect such issues in it. Similarly, the Government's view was that including a duty of openness, transparency and candour into contracts of employment was not 'relevant', partly due to the difficulty in defining these terms. The recommendation was better delivered, in its view, by improved appraisal systems.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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Improving NHS culture and governance	**179.**	Gagging clauses or non-disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners, insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said it required the inclusion of an explicit clause in compromise agreements to make it clear to staff signing one that they could make a disclosure in the public interest in accordance with the Public Interest Disclosure Act, regardless of what other clauses might be included in the agreement.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**180.**	Guidance and policies should be reviewed to ensure that they will lead to compliance with Being Open, the guidance published by the National Patient Safety Agency. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that advice such as the Being Open framework would be considered as it consulted on the planned duty of candour. In the February 2015 Culture Change report, the Government said that the Department of Health had worked to ensure that the duty of candour regulations were congruent with the Being Open framework.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**181.**	A statutory obligation should be imposed to observe a duty of candour: (i) On healthcare providers who believe or suspect that treatment provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request.	This recommendation was accepted by the Government in principle. In the January 2014 Hard Truths report, the Government said it would consult on proposals about where trusts should reimburse a proportion or all of the NHS Litigation Authority's compensation costs when they had not been open about a safety incident. Reg. 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 imposed a duty of candour on	Hard Truths: The Journey to Putting Patients First: Volume Two The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	

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		(ii) On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable. Non-compliance should entitle the patient to a remedy. (February 2013)	health service bodies. It did not impose a statutory obligation on individual medical practitioners or nurses. A joint statement was issued on behalf of the Chief Executives of the statutory regulators of healthcare professionals (including the General Medical Council and the Nursing and Midwifery Council) in October 2014 stating their common approach to the professional duty of candour.	Joint statement from the Chief Executives of statutory regulators of healthcare	
Improving NHS culture and governance	**182.**	There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation, where given in compliance with a statutory obligation on the organisation to provide it. (February 2013)	This recommendation was accepted by the Government. The Government enacted the offence of supplying, publishing or otherwise making available false or misleading information under section 92 of the Care Act 2014. The offence extended to any information supplied, published or otherwise made available in response to a statutory or other legal requirement. Public bodies which provide health services, as well as those who provide health services pursuant to arrangements made with a public body, can be prosecuted for the offence, as well as directors of such organisations.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Care Act 2014	
Improving NHS culture and governance	**183.**	It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation:	This recommendation was not accepted by the Government. In the January 2014 Hard Truths report, the Government took the view that:	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		(i) Knowingly to obstruct another in the performance of these statutory duties. (ii) To provide information to a patient or nearest relative intending to mislead them about such an incident. (iii) Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties.	• An individual obstruction offence was not necessary at the time. • It did not intend to criminalise untruthful statements to commissioners and regulators made by healthcare professionals, but would legislate for the prosecution of directors and senior individuals (see offence of providing false or misleading information).		
Improving NHS culture and governance	**184.**	Observance of the duty should be policed by the Care Quality Commission, which should have powers in the last resort to prosecute in cases of serial non-compliance or serious and wilful deception. The Care Quality Commission should be supported by monitoring undertaken by commissioners and others. (February 2013)	This recommendation was accepted by the Government in relation to the statutory duty of candour. The Care Quality Commission was given powers of enforcement of the duty, including warning and requirement notices, imposition of conditions and criminal prosecutions.	Hard Truths: The Journey to Putting Patients First: Volume Two How we regulate the duty of candour - Care Quality Commission	
Nursing					
Improving patient safety	**185.**	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires:	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Nursing and Midwifery Council had introduced new education standards (these were introduced in 2010, with all universities required to be compliant by September 2013), requiring students to be tested for aptitude in literacy, numeracy and communication skills, and assessed	Hard Truths: The Journey to Putting Patients First: Volume Two NMC response to the Francis report	

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		(i) Selection of recruits to the profession who evidence the possession of the appropriate values, attitudes and behaviours; ability and motivation to enable them to put the welfare of others above their own interests; drive to maintain, develop and improve their own standards and abilities; intellectual achievement to enable them to acquire through training the necessary technical skills. (ii) Training and experience in delivery of compassionate care. (iii) Leadership which constantly reinforces values and standards of compassionate care. (iv) Involvement in, and responsibility for, the planning and delivery of compassionate care. (v) Constant support and incentivisation which values nurses and the work they do. (February 2013)	as to health and good character on admission to programmes. Students were required to pass all assessments at every progression point before they completed their programmes and were assessed for good health and good character as to their fitness for award and fitness to practice. The Government also referred to NHS Leadership Academy's new leadership development programme, which was to focus on values, attitudes and behaviours. The Government said that NHS England was working with Health Education England to embed the '6Cs' set out in 'Compassion in Practice' in all nursing and midwifery education and training. The Government also said its mandate to Health Education England contained a requirement to ensure that selection into all new NHS-funded training posts incorporates testing of values. The Government also said that NHS England was working with Health Education England and NHS Employers to support the introduction of value-based recruitment and appraisal for all registered or unregistered staff. In the February 2015 Culture Change report, the Government said that the Nursing and Midwifery Council was in the final stages of appointing an independent evaluation supplier and had commenced the evaluation of their standards for pre-registration education for nurses and midwives.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex IFF Report - Evaluation of the NMC Pre-Registration Standards: Final Report	

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			The Nursing and Midwifery Council undertook a review of the new education standards was completed in 2015. The review concluded that the standards were broadly effective, but that there were points of consideration for future development or revision of standards, including revision of use of language to reduce ambiguity; improvement in the structure of standards; further promotion of awareness of their content among key audiences; some outcomes to be added to the standards; and further entry criteria.		
Improving patient safety	**186.**	Nursing training should be reviewed so that sufficient practical elements are incorporated to ensure that a consistent standard is achieved by all training throughout the country, through national standards. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Nursing and Midwifery Council had introduced new education standards (see above). The Nursing and Midwifery Council also undertook a review of the new education standards in 2014-15. The review concluded that the standards were broadly effective, but that there were points of consideration for future development or revision of standards, including revision of use of language to reduce ambiguity; improvement in the structure of standards; further promotion of awareness of their content among key audiences; some outcomes to be added to the standards; and further entry criteria.	Hard Truths: The Journey to Putting Patients First: Volume Two IFF Report - Evaluation of the NMC Pre-Registration Standards: Final Report	
Improving patient safety	**187.**	There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care. Satisfactory completion of this direct care experience should be	This recommendation was accepted by the Government. The Government, through Health Education England, established a pilot programme placing students seeking NHS funding for NHS degrees on placements up to a year-long working as a healthcare assistant, which extended into spring 2015.	Hard Truths: The Journey to Putting Patients First: Volume Two NMC response to the Francis report	

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		a pre-condition to continuation in nurse training. Supervised work of this type as a healthcare support worker should be allowed to count as an equivalent. An alternative would be to require candidates for qualification for registration to undertake a minimum period of work in an approved healthcare support worker post involving the delivery of such care. (February 2013)	The Nursing and Midwifery Council's July 2013 response was that the requirement for all full time nursing education programmes to involve at least 50% of time spent in hands-on training in a practice setting, met the 'spirit as well as the letter' of the recommendation. The Nursing and Midwifery Council did not consider that requiring candidates for nursing education programmes to undertake a minimum period in a healthcare support role would advance patient safety. The Royal College of Nursing's view was that this recommendation failed to acknowledge the extent of practical experience which was already on offer.	RCN-response-to-Francis-Inquiry-Report	
Improving patient safety	**188.**	The Nursing and Midwifery Council, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates' attitudes towards caring, compassion and other necessary professional values.	This recommendation was accepted by the Government in principle. The January 2014 Hard Truths report said that the Nursing and Midwifery Council had introduced new education standards (these were introduced in 2010, with all universities required to be compliant by September 2013), requiring students to be tested for aptitude in literacy, numeracy and communication skills, and assessed as to	Hard Truths: The Journey to Putting Patients First: Volume Two	

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Improving NHS culture and governance		(February 2013)	health and good character on admission to programmes. Students would be required to pass all assessments at every progression point before they completed their programmes and be assessed for good health and good character as to their fitness for award and fitness to practice. It does not appear an aptitude test was introduced for nurses trained in England.		
Improving patient safety	**189.**	The Nursing and Midwifery Council and other professional and academic bodies should work towards a common qualification assessment/examination. (February 2013)	This recommendation was accepted by the Government in principle. In the January 2014 Hard Truths report, the Government's view was that this was a matter for the Nursing and Midwifery Council. It is unclear how, if at all, this was considered or actioned by the Nursing and Midwifery Council.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**190.**	There should be national training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of the fundamental aspects of compassionate care. (February 2013)	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, the Government said that the Nursing and Midwifery Council had already set standards for undergraduate degrees, but Health Education England, NHS England and the Nursing and Midwifery Council would work together to ensure newly qualified nurses were competent at the point of registration. Unclear what further was done. In the February 2015 Culture Change report, the Government said that Health Education England local	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			education and training boards had developed preceptorship standards with their stakeholders.		
Improving patient safety	**191.**	Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values attitudes and behaviours towards the wellbeing of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that its mandate to Health Education England contained a requirement to ensure that selection into all new NHS-funded training posts incorporated testing of values. The Government also said that NHS England was working with Health Education England and NHS Employers to support the introduction of value-based recruitment and appraisal for all registered or unregistered staff. In the February 2015 Culture Change report, the Government said this had resulted in development of a mapping tool to allow local organisations to map their values to those in the NHS Constitution.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**192.**	The Department of Health and the Nursing and Midwifery Council should introduce the concept of a Responsible Officer for nursing, appointed by and accountable to the Nursing and Midwifery Council. (February 2013)	This recommendation was accepted in principle by the Government. The Nursing and Midwifery Council's view was that a revalidation scheme would be more proportionately introduced without Responsible Officers. Such a scheme of revalidation was introduced in April 2016.	Hard Truths: The Journey to Putting Patients First: Volume Two NMC response to the Francis report	
Improving patient safety	**193.**	Without introducing a revalidation scheme immediately, the Nursing and Midwifery Council should introduce common minimum standards for appraisal and support with which responsible	This recommendation was accepted in principle by the Government.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		officers would be obliged to comply. They could be required to report to the Nursing and Midwifery Council on their performance on a regular basis. (February 2013)	In the January 2014 Hard Truths report, the Government said that, in advance of the introduction of revalidation by the Nursing and Midwifery Council, NHS Employers planned to support NHS organisations in developing and improving values-based appraisal and performance management and encourage NHS organisations to make the necessary links with the Nursing and Midwifery Council's work on revalidation as they developed new local performance and appraisal arrangements. The Nursing and Midwifery Council published a revised Code in January 2015, effective from 31 March 2015.	Revised Code for nurses and midwives published - The Nursing and Midwifery Council	
Improving patient safety	**194.**	As part of a mandatory annual performance appraisal, each nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said that it considered the aim of the recommendation was best achieved through the introduction of nursing revalidation. The nursing revalidation process was introduced in April 2016.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		accurate and true reflection and be countersigned by their appraising manager as being such. (February 2013)			
Improving patient safety	**195.**	Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said that there needed to be local flexibility in delivering nursing care, so it would not mandate that ward managers should only operate in a supervisory capacity. However, the Government stated its strong support for supervisory roles for ward managers. In its February 2015 Culture Change report, the Government said that NHS England was considering whether further work was needed to assess the impact of supervisory nurses.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**196.**	The Knowledge and Skills Framework should be reviewed with a view to giving explicit recognition to nurses' demonstrations of commitment to patient care and, in particular, to the priority to be accorded to dignity and respect, and their acquisition of leadership skills. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said had the Freedom use the Knowledge and Skills Framework to develop their own local arrangements to ensure that dignity, respect and leadership is fully reflected	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying	

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Improving NHS culture and governance			in staff training and development and the same is part of local appraisal systems. The Knowledge and Skills Framework was not mentioned in the 2015 Culture Change report and it is unclear whether any review of the Framework was undertaken.	the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety **Improving NHS culture and governance**	**197.**	Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff. (February 2013)	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, the Government said that the NHS Leadership Academy core programmes would provide a structured and robust leadership development education from entry-level to executive-level. The Government stated that arrangements for training were primarily the responsibility of providers, but when commissioners deemed it necessary, they could set training requirements in their contracts with providers.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**198.**	Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust methodology, such as the “cultural barometer”. (February 2013)	This recommendation was accepted by the Government. In its January 2014 Hard Truths repot, the Government said that the Department of Health was promoting various tools and methods to maintain good cultural health. T In the February 2015 Culture Change report, the Government said that the Staff Friends and Family Test was introduced in April 2014, providing a feedback tool for staff.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			Piloting was carried out for the “Culture of Care Barometer”, which resulted in the publication of a guide for how organisations could implement the Barometer in April 2017. It is unclear what, if any, incentives were implemented.	‘Culture of Care' Barometer	
Improving patient safety	**199.**	Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient. (February 2013)	This recommendation was accepted by the Government. The Secretary of State for Health announced his support for patients having a named nurse in July. It was not made a mandatory requirement. The Academy of Medical Royal Colleges was asked by the Government to produce guidance on the issue, which it published in June 2014.	Hard Truths: The Journey to Putting Patients First: Volume Two Taking Responsibility Accountable Clinicians	
Improving patient safety	**200.**	Consideration should be given to the creation of a status of Registered Older Person’s Nurse. (February 2013)	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, the Government stated it considered this recommendation and it felt there were better ways of improving nursing care for older people, for example by nurse training. The Government asked Health Education England to work with higher education institution to review the content of pre-registration nurse education to ensure all new nurses had the skills to work with older people. Health Education England were to develop a bespoke older persons nurse postgraduate qualification raining programme, which would allow nurses to become part of an Older Persons Nurse Fellowship programme. This was piloted in 2015-16.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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Improving NHS culture and governance	**201.**	The Royal College of Nursing should consider whether it should formally divide its "Royal College" functions and its employee representative/trade union functions between two bodies rather than behind internal "Chinese walls". (February 2013)	This recommendation was accepted by the Government. The Royal College of Nursing considered the proposal in its July 2013 response, but decided it would not split its trade union and professional functions.	Hard Truths: The Journey to Putting Patients First: Volume Two RCN-response-to-Francis-Inquiry-Report	
Improving NHS culture and governance	**202.**	Recognition of the importance of nursing representation at provider level should be given by ensuring that adequate time is allowed for staff to undertake this role, and employers and unions must regularly review the adequacy of the arrangements in this regard. (February 2013)	This recommendation was accepted by the Government. The Government's position (per the January 2014 Hard Truths Report) was that this was a matter for local employers and unions. The Royal College of Nursing, UNISON and NHS Employees each endorsed the recommendation.	Hard Truths: The Journey to Putting Patients First: Volume Two RCN-response-to-Francis-Inquiry-Report	
Improving NHS culture and governance	**203.**	A forum for all directors of nursing from both NHS and independent sector organisations should be formed to provide a means of coordinating the leadership of the nursing profession. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Chief Nursing Officer had established the Federation of Nurse Leaders, with its membership drawn from various bodies, including the Care Quality Commission, the NHS Trust Development Authority, Health Education England, the Department of Health and Public Health England. The Government said the Federation provided advice, challenge and scrutiny of nursing issues and oversight of nursing vision and strategy in England. The Government also referred to the Nurse and Care Quality forum and its role in advising the Government on nursing and care quality issues.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			In the February 2015 Culture Change report, the Government said that the Federation of Nurse Leaders remained active.		
Improving NHS culture and governance	**204.**	All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors. (February 2013)	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, the Government said that all provider organisations had at least one executive director who is a registered nurse and that NHS England had a Chief Nursing Officer on its executive board and director level (although not executive level) representation at area and regional team levels. The Government referred to the National Health Service (Clinical Commissioning) Regulations 2012 as requiring clinical commissioning groups to have a nurse on their governing body, but not necessarily at executive level with the Government saying this enabled local flexibility.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**205.**	Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so. (February 2013)	This recommendation was accepted by the Government in principle. In the January 2014 Hard Truths report, the Government said that NHS England had asked that that decisions on quality improvement plans were signed off by medical and nursing directors, and were considering to ask for their sign off on staffing changes for clinical staff as well as service provision. It is unclear whether this was done.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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Improving NHS culture and governance	**206.**	The effectiveness of the newly positioned office of Chief Nursing Officer should be kept under review to ensure the maintenance of a recognised leading representative of the nursing profession as a whole, able and empowered to give independent professional advice to the Government on nursing issues of equivalent authority to that provided by the Chief Medical Officer. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government stated it would keep the effectiveness of the Chief Nursing Officer reviewed on an ongoing basis. No update was provided in the February 2015 Culture Change report.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**207.**	There should be a uniform description of healthcare support workers, with the relationship with currently registered nurses made clear by the title. (February 2013)	This recommendation was accepted by the Government in principle. In the January 2014 Hard Truths report, the Government said that, as healthcare support workers carried out a number of different tasks in varied roles, a uniform description could be difficult. The Government referred to the Cavendish Review recommending that once healthcare assistants and healthcare support workers completed a 'Certificate of Fundamental Care' they should be allowed to use the title 'Nursing Assistant'.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**208.**	Commissioning arrangements should require provider organisations to ensure by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse. (February 2013)	This recommendation was accepted by the Government in principle. In the January 2014 Hard Truths report, the Government agreed that patients should be clear on the role of people caring for them, through identity labels, clear job titles and uniforms. However, it referred to the Cavendish Review, which did not make a firm recommendation that healthcare assistants	Hard Truths: The Journey to Putting Patients First: Volume Two	

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			and nurses wear distinct uniforms, as many Trusts already developed their own.		
Improving patient safety	**209.**	A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability and/or infirmity) in a hospital or care home setting. The system should apply to healthcare support workers, whether they are working for the NHS or independent healthcare providers, in the community, for agencies or as independent agents. (Exemptions should be made for persons caring for members of their own family or those with whom they have a genuine social relationship.) (February 2013)	This recommendation was not accepted by the Government. In the January 2014 Hard Truths report, the Government said that regulation by itself did not prevent poor care, and in fact could be costly and introduce inflexibility into the system. The Government stated that there was no solid evidence to demonstrate that healthcare and care support workers should be subject to compulsory statutory regulation. The Government instead referred to the code of conduct and minimum training standards for healthcare assistants and support workers in England, published in March 2013. In the February 2015 Culture Change report, the Government referred to the introduction of a Care Certificate for new healthcare assistance and social care support workers from 1 April 2015, with the Care Certificate setting out the fundamental skills, values and behaviours that healthcare assistance and social care support workers would need to demonstrate.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Code of Conduct	
Improving patient safety	**210.**	There should be a national code of conduct for healthcare support workers. (February 2013)	This recommendation was accepted by the Government. A national code of conduct for healthcare support workers and adult social workers was published in March 2013.	Hard Truths: The Journey to Putting Patients First: Volume Two Code of Conduct	

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Improving patient safety	**211.**	There should be a common set of national standards for the education and training of healthcare support workers. (February 2013)	This recommendation was accepted by the Government. The National Minimum Training Standards for healthcare support workers were published in March 2013. The Care Certificate was introduced for new healthcare assistance and social care support workers from 1 April 2015, setting out the fundamental skills, values and behaviours that healthcare assistance and social care support workers would need to demonstrate. It replaced both the National minimum Training Standards and the Common Indication Standards, with all NHS-funded student nurses in England to attain the Care Certificate within their first year of study.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex National Minimum Training Standards for Healthcare Support Workers	
Improving patient safety	**212.**	The code of conduct, education and training standards and requirements for registration for healthcare support workers should be prepared and maintained by the Nursing and Midwifery Council after due consultation with all relevant stakeholders, including the Department of Health, other regulators, professional representative organisations and the public. (February 2013)	This recommendation was not accepted by the Government. In the January 2014 Hard Truths report, the Government said that this was a step towards regulation, which should be rejected.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**213.**	Until such time as the Nursing and Midwifery Council is charged with the recommended regulatory responsibilities, the Department of Health should institute a nationwide system to protect patients and care receivers from harm. This system should be supported by fair due process in relation to employees in this grade who have been dismissed by employers on the grounds of a serious	This recommendation was rejected by the Government. In the January 2014 Hard Truths report, the Government rejected the recommendation that the Nursing and Midwifery Council be charged with the recommended regulatory responsibilities for healthcare assistants and support workers. The Government said that it had instead commissioned the Professional Standards Authority for	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the	

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		breach of the code of conduct or otherwise being unfit for such a post. (February 2013)	Health and Social Care for advice on how employees could be more effective in managing the dismissal of unsatisfactory staff. In the February 2015 Culture Change report, the Government referred to the Care Quality Commission's registration requirements requiring providers to have the right staff with the right qualifications, competence, skills and experience; the Nursing and Midwifery Council's Code of Conduct requiring nurses and midwives to delegate effectively; and the NHS Employers and the National Skills Academy for Social Care being commissioned to develop a resource drawing together content on effective performance management and appraisal of staff.	Francis Inquiries: Supporting Annex	
Leadership					
Improving NHS culture and governance	**214.**	A leadership staff college or training system, whether centralised or regional, should be created to: provide common professional training in management and leadership to potential senior staff; promote healthcare leadership and management as a profession; administer an accreditation scheme to enhance eligibility for consideration for such roles; promote and research best leadership practice in healthcare. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the NHS Leadership Academy, launched in April 2012, performed this role. In the February 2015 Culture Change report, the Government referred to the launching of the Executive Fast Track programme in June 2014, aimed at increased the number of executive leaders in the NHS.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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Improving NHS culture and governance **Regulation and oversight of NHS managers**	**215.**	A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it. (February 2013)	This recommendation was accepted by the Government. The Professional Standards Authority published 'Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England' in May 2013. The NHS Leadership Academy published 'The Healthy NHS Board 2013', which included guidance on supporting board effectiveness and the importance of values and behaviours. It is unclear the extent of steps taken to oblige staff to comply with the above guidance and standards and the steps by employers to enforce it. In the February 2015 Culture Change report, the Government referred to the introduction of the fit and proper persons test.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Standards for NHS boards and CCG governing bodies in England | PSA	
Improving NHS culture and governance	**216.**	The leadership framework should be improved by increasing the emphasis given to patient safety in the thinking of all in the health service. This could be done by, for example, creating a separate domain for managing safety, or by defining the service to be delivered as a safe and effective service. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the NHS Leadership Academy was developing a new healthcare leadership model for the NHS. This was published in November 2013, and comprised of nine leadership dimensions, setting out the qualities that it thought good leaders at all levels in the NHS should express.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the	

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				Francis Inquiries: Supporting Annex Healthcare Leadership Model – Leadership Academy	
Improving NHS culture and governance	**217.**	A list should be drawn up of all the qualities generally considered necessary for a good and effective leader. This in turn could inform a list of competences a leader would be expected to have. (February 2013)	This recommendation was accepted in the part by the Government. In the January 2014 Hard Truths report, the Government said that the NHS Leadership Academy had developed a new healthcare leadership model. The Government also referred to the 'Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England' published by the Professional Standards Authority as providing the standards for senior board-level leaders and managers. In the February 2015 Culture Change report, the Government referred to the NHS Leadership Academy's new healthcare leadership model for the NHS, published in November 2013, and comprised of nine leadership dimensions, setting out the qualities that it thought good leaders at all levels in the NHS should express. The Government also said that the National Skills Academy for Social Care's Leadership Qualities Framework described what good leadership looked like in different setting and situations.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Healthcare Leadership Model – Leadership Academy Standards for NHS boards and CCG governing bodies in England | PSA	

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Improving NHS culture and governance **Regulation and oversight of NHS managers**	**218.**	Serious non-compliance with the code, and in particular, non-compliance leading to actual or potential harm to patients, should render board-level leaders and managers liable to be found not to be fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them from holding such positions in future. (February 2013)	This recommendation was accepted by the Government. The Care Quality Commission was to determine how the fit and proper person test would be applied in practice so it drew upon the standards set out in the 'Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England' published by the Professional Standards Authority.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance **Regulation and oversight of NHS managers**	**219.**	An alternative option to enforcing compliance with a management code of conduct, with the risk of disqualification, would be to set up an independent professional regulator. The need for this would be greater if it were thought appropriate to extend a regulatory requirement to a wider range of managers and leaders. The proportionality of such a step could be better assessed after reviewing the experience of a licensing provision for directors. (February 2013)	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, the Government said that a focus on standards and their enforcement through normal employment processes and a fit and proper person test was the right place to start. It accepted that further action might be justified following a review of how the approached worked in practice. In the February 2015 Culture Change report, the Government said that it would be the responsibility of the provider, and in the case of NHS bodies, the chair, to ensure that all directors met the fitness test and did not meet any of the 'unfit' criteria. The Government said it monitor the reforms.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**220.**	A training facility could provide the route through which an accreditation scheme could be organised. Although this might be a voluntary scheme, at least	This recommendation was accepted in part by the Government.	Hard Truths: The Journey to Putting	

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Regulation and oversight of NHS managers		initially, the objective should be to require all leadership posts to be filled by persons who experience some shared training and obtain the relevant accreditation, enhancing the spread of the common culture and providing the basis for a regulatory regime. (February 2013)	In the January 2014 Hard Truths report, Government rejected the need for a formal accreditation scheme. Instead, it referred to the national leadership development programmes launched by the NHS Leadership Academy. In the February 2015 Culture Change report, the Government said that the NHS Leadership Academy's core programmes were accredited, with a consistent approach to identifying and developing current and future NHS leaders with the right skills and behaviours.	Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance **Regulation and oversight of NHS managers**	**221.**	Consideration should be given to ensuring that there is regulatory oversight of the competence and compliance with appropriate standards by the boards of health service bodies which are not foundation trusts, of equivalent rigour to that applied to foundation trusts. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Care Quality Commission would be responsible for ensuring that all registered providers and appropriate and effective governance arrangements when assessing the overall health of the organisation, regardless of whether or not it was a foundation trust. One of the questions it would ask during an inspection is whether or not an organisation was well-led. The NHS Trust Development Authority was to be responsible for ensuring that NHS Trusts had effective governance arrangements in place.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Professional regulation of fitness to practice					
Improving the ability to make and raise complaints	**222.**	The General Medical Council should have a clear policy about the circumstances in which a generic complaint or report ought to be made to it, enabling a more proactive approach to monitoring fitness to practise. (February 2013)	This recommendation was accepted by the Government. The General Medical Council said in its October 2014 update that it contributed to the identification and investigation of systemic or generic concerns by: sign posting complaints to the appropriate regulator if their	Hard Truths: The Journey to Putting Patients First: Volume Two	

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			concerns were not for the General Medical Council, making referrals to systems or other professional regulators, investigating concerns that were raised in the media and sharing information with and participating in Regional Quality Surveillance Group and Risk Assessment. In the February 2015 Culture Change report, the Government said that direct intervention by the General Medical Council would be confined to matters within its regulatory remit in the quality of education and of individual practitioners. It is unclear whether any clear policy was developed.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex October 2014 update on the GMC's work to address the Francis Recommendations	
Improving the ability to make and raise complaints	**223.**	If the General Medical Council is to be effective in looking into generic complaints and information it will probably need either greater resources, or better cooperation with the Care Quality Commission and other organisations such as the Royal Colleges to ensure that it is provided with the appropriate information. (February 2013)	This recommendation was accepted by the Government in principle. In the January 2014 Hard Truths report, the Government referred to the General Medical Council information sharing protocol with the Care Quality Commission. In the February 2015 Culture Change report, the Government said that the General Medical Council had developed an operational protocol with the Care Quality Commission and was in the process of agreeing a memorandum of understanding/information sharing agreement with Monitor. The Government also said the General Medical Council had developed a new information sharing manual for fitness to practise colleagues, detailing at an operational level how, when and who with the General Medical Council would share.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Our memoranda of understanding - GMC	

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			The General Medical Council also entered into information sharing agreement with the Academy of Medical Royal Colleges in September 2016.		
Improving the ability to make and raise complaints	**224.**	Steps must be taken to systematise the exchange of information between the Royal Colleges and the General Medical Council, and to issue guidance for use by employers of doctors to the same effect. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the General Medical Council had produced guidance to help employers understand when to share information with the General Medical Council. The General Medical Council entered into an information sharing agreement with the Academy of Medical Royal Colleges in September 2016.	Hard Truths: The Journey to Putting Patients First: Volume Two Our memoranda of understanding - GMC	
Improving the ability to make and raise complaints	**225.**	The General Medical Council should have regard to the possibility of commissioning peer reviews pursuant to section 35 of the Medical Act 1983 where concerns are raised in a generic way, in order to be advised whether there are individual concerns. Such reviews could be jointly commissioned with the Care Quality Commission in appropriate cases. (February 2013)	This recommendation was accepted by the Government. The Government said in the January 2014 Hard truths report that the General Medical Council had made it clear that it was determined to work with others to explore the development of appropriate forms of joint ownership of generic issues, which could include peer reviews.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving the ability to make and raise complaints	**226.**	To act as an effective regulator of nurse managers and leaders, as well as more front-line nurses, the Nursing and Midwifery Council needs to be equipped to look at systemic concerns as well as individual ones. It must be enabled to work closely with the systems regulators and to share their information and analyses on the working of systems in organisations in which nurses are active. It	This recommendation was accepted in part by the Government. In its July 2013 response, the Nursing and Midwifery Council stated it did not wish to be given the role of directly investigating systems issues, and that primary responsibility lay with the Care Quality Commission and other regulators.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the	

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		should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures. Full access to the Care Quality information in particular is vital. (February 2013)	The Nursing and Midwifery Council said it would work more closely with the systems regulators and share their information and analyses on the working of systems in organisation in which nurses and midwives are active. In the 2015 Culture Change report, the Government said that the Nursing and Midwifery Council had updated its memoranda of understanding with the Care Quality Commission, setting out how and when they would share information.	Francis Inquiries: Supporting Annex NMC response to the Francis report	
Improving the ability to make and raise complaints	**227.**	The Nursing and Midwifery Council needs to have its own internal capacity to assess systems and launch its own proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues. It may decide to seek the cooperation of the Care Quality Commission, but as an independent regulator it must be empowered to act on its own if it considers it necessary in the public interest. This will require resources in terms of appropriately expert staff, data systems and finance. Given the power of the registrar to refer cases without a formal third party complaint, it would not appear that a change of regulation is necessary, but this should be reviewed. (February 2013)	This recommendation was accepted in principle by the Government. In its July 2013 response, the Nursing and Midwifery Council did not support the recommendation that it should be tasked directly with investigating systems issues, pointing to the distinct roles and responsibilities of professional and systems regulators. The Nursing and Midwifery Council considered that working closer together with the Care Quality Commission and other systems regulators on patient safety issues would provide a better solution. In the February 2015 Culture Change report, the Government said that the Nursing and Midwifery Council used its powers to open cases if there was a public interest in doing so.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex NMC response to the Francis report	

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Improving NHS culture and governance	**228.**	It is of concern that the administration of the Nursing and Midwifery Council, which has not been examined by the Inquiry, is still found by other reviews to be wanting. It is imperative in the public interest that this is remedied urgently. Without doing so, there is a danger that the regulatory gap between the Nursing and Midwifery Council and the Care Quality Commission will widen rather than narrow. (February 2013)	This recommendation was accepted by the Government. In its July 2013 response, the Nursing and Midwifery Council said it was making good progress against the recommendations in the strategic review carried out by the Professional Standards Authority. In the January 2014 Hard Truths report, the Government referred to amendments made to the legislative framework in relation to fitness to practise procedure, to make them more efficient. The Government also referred to leadership change at the Nursing and Midwifery Council in 2012 and 2013, as well as the provision of a £20m government grant to it in 2013. The Nursing and Midwifery (Amendment) Order 2014 made amendments to the Nursing and Midwifery Council's governing legislative framework. Further changes were made in the Nursing and Midwifery (Amendment) Order 2017. In the February 2015 Culture Change report, the Government said that the Nursing and Midwifery Council had cleared the backlog of historical fitness to practice cases in summer 2014.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex NMC response to the Francis report	
Improving patient safety	**229.**	It is highly desirable that the Nursing and Midwifery Council introduces a system of revalidation similar to that of the General Medical Council, as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. It is essential that the	This recommendation was accepted by the Government. The nursing revalidation process was introduced in April 2016.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		Nursing and Midwifery Council has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses. (February 2013)		NMC response to the Francis report	
Improving NHS culture and governance	**230.**	The profile of the Nursing and Midwifery Council needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed, by those providing treatment or care, of the existence and role of the Nursing and Midwifery Council, together with contact details. The Nursing and Midwifery Council itself needs to undertake more by way of public promotion of its functions. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Nursing and Midwifery Council re-launching its website (re-launched in mid-2015), developing information for patients, the public and employers, embarking on programme of increased face-to-face engagement with stakeholders, and introducing a new patient and public forum. The Nursing and Midwifery Council said it would publish a leaflet for the public on how to raise concerns and promote and distribute the leaflet through patient and other third sector organisations. In its March 2014 update report, the Nursing and Midwifery Council said it would undertake a survey of perceptions of it.	Hard Truths: The Journey to Putting Patients First: Volume Two 6-months-on-francis-update	
Improving NHS culture and governance	**231.**	It is essential that, so far as practicable, Nursing and Midwifery Council procedures do not obstruct the progress of internal disciplinary action in providers. In most cases it should be possible, through cooperation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures, to make it clear that the employer is entitled to proceed even if there are	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Nursing and Midwifery Council's view was that its fitness to practise procedures did not obstruct the progress of internal disciplinary action by providers, and that in most cases it would expect the provider or employer to complete its own internal investigation before making a referral. The Nursing and Midwifery Council said it would	Hard Truths: The Journey to Putting Patients First: Volume Two NMC response to the Francis report	

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		pending Nursing and Midwifery Council proceedings. (February 2013)	review the guidance it provided to employers and the public on fitness to practise processes.		
Improving NHS culture and governance	**232.**	The Nursing and Midwifery Council could consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing. If this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap. (February 2013)	This recommendation was accepted by the Government. The Nursing and Midwifery Council said it would carry out a pilot in 2014 for a role of regional advisors, to perform a function similar to the General Medical Council's employment liaison advisers. In the February 2015 Culture Change report, the Government said that an operating model was being developed for rollout in early 2015. It is unclear how this was taken forward.	Hard Truths: The Journey to Putting Patients First: Volume Two NMC response to the Francis report	
Improving NHS culture and governance	**233.**	While both the General Medical Council and the Nursing and Medical Council have highly informative internet sites, both need to ensure that patients and other service users are made aware at the point of service provision of their existence, their role and their contact details. (February 2013)	This recommendation was accepted by the Government. In 2012, the General Medical Council piloted a Patient Information Service with the aim of improving communications with members of the public who raise concerns about a doctor, with plans for the pilot to be rolled out across the UK. Reference to its Regional Liaison Service developing engagement with patients and the public, discussing its guide 'What to Expect from Your Doctor' as well as the General Medical Council's general role. The pilot was rolled out to offices across the UK in January 2015. In its July 2013 response, the Nursing and Midwifery Council said it also supported this recommendation. In the February 2015 Culture Change report, the Government referred to the re-launch of the Nursing and Midwifery Council' website in mid-2015, its Patient and Public Engagement Forum, and the production of 2 information	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex October 2014 update on the GMC's work to address the Francis Recommendations NMC response to the Francis report	

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			leaflets for the public on raising concerns about nurses and midwives.		
Improving NHS culture and governance	**234.**	Both the General Medical Council and the Nursing and Midwifery Council must develop closer working relationships with the Care Quality Commission – in many cases there should be joint working to minimise the time taken to resolve issues and maximise the protection afforded to the public. (February 2013)	Accepted by the Government. The Nursing and Midwifery Council and the Care Quality Commission renewed their memorandum of understanding in December 2013, supporting by joint working protocol. The General Medical Council also developed an operational protocol with the Care Quality Commission.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex CQC and GMC Joint Operational Protocol (2020) jwp-nmc-cqc-11-2017-update-na	
Improving NHS culture and governance	**235.**	The Professional Standards Authority for Health and Social Care together with the regulators under its supervision, should seek to devise procedures for dealing consistently and in the public interest with cases arising out of the same event or series of events but involving professionals regulated by more than one body. While it would require new regulations, consideration should be given to the possibility of moving towards a common independent tribunal to determine fitness to practise	This recommendation was accepted in part by the Government. The Government stated that the Professional Standards Authority had no power to intervene directly in cases (save where it considered the outcome of a fitness to practise hearing had been unduly lenient) The Law Commission reported in April 2014, producing a draft Bill setting out a single legal framework for the regulation of all health and social care professionals and imposing greater consistency in respect of the conduct of	Hard Truths: The Journey to Putting Patients First: Volume Two Regulation of Health and Social Care Professionals - Law Commission	

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		issues and sanctions across the healthcare professional field. (February 2013)	fitness to practise hearings. The Government published its response in January 2015, largely accepting the recommendations.		
Caring for the elderly					
Improving patient safety	**236.**	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Department of Health indicated its support for this practice and said it would encourage providers to adopt it. The Academy of Medical Royal Colleges published guidance in June 2014 supporting the recommendation. In the February 2015 Culture Change report, the Government said that more than 2/3 of trusts had reported they had implemented the 'Name Above the Bed' or a similar initiative. The Government also said that adoption of the Academy of Medical Royal Colleges' guidance on the role of the responsible clinician would be reflect in the regulatory and planning frameworks for the NHS, with the professions, NHS England and employer to consider what further action was needed to foster a stronger culture of professional responsibility for individual patients.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex Taking Responsibility Accountable_Clinicians	
Improving patient safety	**237.**	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued. (February 2013)	This recommendation was accepted by the Government. In the Government said that the Department of Health had h asked NHS Employers to collate the resources available to employers to support team development and effective teamworking, and create a webpage with links to these resources.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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Improving patient safety	**238.**	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: (i) All staff need to be enabled to interact constructively with patients and visitors. (ii) Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. (iii) The NHS should develop a greater willingness to communicate by email with relatives. (iv) The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.	This recommendation was accepted by the Government. In its January 2014 Hard Truths Report, the Government said that as part of its Mandate for 2013-15 it had asked Health Education England to work with healthcare providers, regulators and educational institutions to ensure recruitment and selection for training identify and reinforcing the values and behaviours identified in the NHS Constitution. The Government referred to the Department of Health's Building Note-04-01, published in December 2012, as recognising the need for breakout space and informal social space, taking into account privacy. The Government set out its expectation that it would expect increased use of technology for appropriate communications with carers, families and relatives.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**239.**	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the guidance 'Ready to Go' setting out clear	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient. (February 2013)	steps for local authorities and the NHS to work together to plan the safe discharge of patients from hospital. The Government said it would spend £1bn from 2010 to 2015 on reablement services to help people regain their independence and confidence following discharge. In the February 2015 Culture Change report, the Government said that referred to the new fundamental standards as reflecting the unacceptability of unsafe discharge.		
Improving patient safety	**240.**	All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these. (February 2013)	This recommendation was accepted by the Government.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**241.**	The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to local Healthwatch using 'enter and view' powers and to enhance the new inspection regimes. The Government also said the Department of Health was awarding grant funding the Malnutrition Taskforce to run a pilot programme to test a framework to reduce malnutrition among older people in a range of health and care settings. Trusts were to be encouraged to implement protected mealtimes and shifts to be organised so that staff are not taking breaks at the same time as patients are being served meals.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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Improving patient safety	**242.**	In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the hospital chief pharmacist would on ensuring that all aspects of medicine use within its organisation are safe. Local hospital pharmacy teams were to ensure systems are in place to minimise risks to patients from medicines, and working with doctors, nurses and management colleagues, ensure those systems are robustly and regularly monitored and audited.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**243.**	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded. (February 2013)	This recommendation was Accepted by the Government. The Government referred to the Prime Minister announcing the Nursing Technology Fund, an investment fund of £100m spread over 2013-2015.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Information					
Improving patient safety	**244.**	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: (i) Patients need to be granted user friendly, real time and retrospective access to read their records, and a	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that Health and Social Care Act 2012 gave the Secretary of State for Health and NHS England powers to publish, or adopt, data standards, that specified how data should be processed, with the Health and Social Care Information also publishing performance information and statistics to be used across the health and care system. The	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the	

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			facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way.	Government referred to access to the summary care record being rolled out across England, with the Department of Health to review options for making them more accessible electronically.	Francis Inquiries: Supporting Annex	
		(ii)	Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry.	The Government stated that, by spring 2015, all patients would be able to see their records, test results, book appointments and order repeat prescriptions online.		
		(iii)	Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered.	GP practices were to set specific requirements for electronic patient records locally, based on national standards to ensure that information can be shared across the system.		
		(iv)	Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input.	In the February 2015 Culture Change report, the Government said that access to the summary Care Record was progressing well, with just over 40 million records available. The Government also said that the timescales for an NHS England Technology Strategy had also been impacted by the development of National Information Board Framework.		
		(v)	Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and			

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		regulatory requirements. (February 2013)			
Improving NHS culture and governance	**245.**	Each provider organisation should have a board level member with responsibility for information. (February 2013)	This recommendation was accepted by the Government in principle. In the January 2014 Hard Truths report, the Government said that it was for trusts to agree the roles and responsibilities of individual Board members locally. However, the Department of Health said it supported clear roles for Executive Directors in taking principal responsibility for providing accurate, timely and clear information to the board.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**246.**	The Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the National Health Service (Quality Accounts Regulations) 2010, the National Health Service (Quality Accounts) Amendment Regulations 22011 and the National Health Service (Quality Accounts) Amendment Regulations 2012 as setting out the prescribed information which must be included in Quality Accounts. This included the value and banding of the summary hospital level mortality indicator and statements of the overview scrutiny committees, relevant clinical commissioning group or NHS England, and the Local Healthwatch. However, there was no reference to this including information about compliance with the fundamental and other standards or proposals for rectification of non-compliance.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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Improving patient safety	**247.**	Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all systems regulators. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the National Health Service (Quality Accounts Regulations) 2010, as requiring Quality Accounts to be published on the NHS Choices website and provided to the local Healthwatch, scrutiny committee and clinical commissioning group. In the February 2015 Culture Change report, the Government said that quality accounts on the NHS Choices website were accessible to all stakeholders. It is unclear whether providers were required to provide quality accounts directly to systems regulators.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**248.**	Healthcare providers should be required to have their quality accounts independently audited. Auditors should be given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to quality accounts being independently audited by external auditors of foundation and non-foundation trusts. In the 2015 Culture Change Report, the Government said that audit skill set was in the main financial, and there needed to be consideration of how current outputs of National Clinical Audit could be included within quality accounts. It appears that there is no longer a national requirement for NHS quality accounts to be audited.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex NHS England » Quality Accounts requirements	

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Improving NHS culture and governance	**249.**	Each quality account should be accompanied by a declaration signed by all directors in office at the date of the account certifying that they believe the contents of the account to be true, or alternatively a statement of explanation as to the reason any such director is unable or has refused to sign such a declaration. (February 2013)	This recommendation was accepted in part by the Government. In the January 2014 Hard Truths report, the Government said that the National Health Service (Quality Accounts Regulations) 2010 required quality accounts to include a written statement signed by the responsible person for the provider that to the best of their knowledge the information in the document is accurate. They did not have to include a separate signature from each director. In the February 2015 Culture Change report, the Government said the review of quality accounts had considered this recommendation, and felt its aims could be better achieved by enabling Healthwatch to challenge quality accounts locally.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex NHS England » Quality accounts FAQs	
Improving NHS culture and governance **Regulation and oversight of NHS managers**	**250.**	It should be a criminal offence for a director to sign a declaration of belief that the contents of a quality account are true if it contains a misstatement of fact concerning an item of prescribed information which he/she does not have reason to believe is true at the time of making the declaration. (February 2013)	This recommendation was accepted in principle by the Government. The Government enacted a wider offence of 'false or misleading information' in section 92 of the Care Act 2014. The offence applied to providers, as well as senior individuals in a provider organisation if they consented to or connived in the offence.	FOMI Guidance	
Improving NHS culture and governance	**251.**	The Care Quality Commission and/or Monitor should keep the accuracy, fairness and balance of quality accounts under review and should be enabled to require corrections to be issued where appropriate. In the event of an organisation failing to take that action, the regulator should be able to	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government stated that responsibility for the accuracy of quality accounts rested with providers, with external auditors to	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		issue its own statement of correction. (February 2013)	provide limited assurance of their accuracy. The Government did not refer to the role of the Care Quality Commission or Monitor.		
Improving NHS culture and governance	**252.**	It is important that the appropriate steps are taken to enable properly anonymised data to be used for managerial and regulatory purposes. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report , the Government referred to the Health and Social Care Information Centre setting a new anonymisation standard from April 2013; guidance published by NHS England in June 2013 advising clinical commissioning groups on the use of data for predictive modelling processes; the Health and Social Care Information Centre allowing pre-publication access to its statistics for management purposes; and the use of anonymised data by the Clinical Practice Research Datalink to improve and safeguard to public health. In December 2014, the Health and Social Care Information Centre published a Code of Practice on Confidential Information.	Hard Truths: The Journey to Putting Patients First: Volume Two HSCIC Code of Practice on Confidential Information	
Improving patient safety	**253.**	The information behind the quality and risk profile – as well as the ratings and methodology – should be placed in the public domain, as far as is consistent with maintaining any legitimate confidentiality of such information, together with appropriate explanations to enable the public to understand the limitations of this tool. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Care Quality Commission's new inspection approach would involve publishing a data pack at that same time as publishing its inspection report, containing analysis of the key information which the Care Quality Commission holds about a provider, including its performance on risk indicators. In June 2013, the Care Quality Commission published an analysis of its monitoring indicators for all acute hospital trusts, showing their performance against the indicators.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			In the February 2015 Culture Change Report, the Government referred to the Care Quality Commission's Intelligent Monitoring System.		
Improving patient safety	**254.**	While there are likely to be many different gateways offered through which patient and public comments can be made, to avoid confusion, it would be helpful for there to be consistency across the country in methods of access, and for the output to be published in a manner allowing fair and informed comparison between organisations. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the mandate for NHS England for April 2013 to March 2015 stated that NHS England would consider how to make it easier for patients and carers to give feedback and see reviews by other people. Unclear to the extent this consistency was implemented. In the February 2015 Culture Change report, the Government referred to the roll out of Friends and Family test, asking patients in acute inpatients and A&E if they would recommend the care they have received to their friends and families, with the results published monthly in all acute inpatient services, A&E and in maternity.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**255.**	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that many local Trusts were devising ways to take this forward. The Government said that NHS England would also make comments accessible in a coherent and consistent manner through NHS Choices, which would be part of national Health and Social Care Digital Service. In the long-term, the Government envisaged that electronic health and care records might be the main vehicle for rating experience of care and leaving feedback and comment.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

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			In the February 2015 Culture Change report, the Government referred to the roll out of Friends and Family test, asking patients in acute inpatients and A&E if they would recommend the care they have received to their friends and families, with the results published monthly in all acute inpatient services, A&E and in maternity.		
Improving patient safety	**256.**	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care. (February 2013)	This recommendation was accepted by the Government. The Government stated it would for trusts to work out how to do this, with the Care Quality Commission assessing complaints as part of its inspection process.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**257.**	The Information Centre should be tasked with the independent collection, analysis, publication and oversight of healthcare information in England, or, with the agreement of the devolved governments, the United Kingdom. The information functions previously held by the National Patient Safety Agency should be transferred to the NHS Information Centre if made independent. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government accepted that the Health and Social Care Information Centre should be made more independent, and in April 2013 established it as an Executive Non-Departmental Public Body. The Government referred to the Health and Social Care Act 2012 requiring the Health and Social Care Information Centre to establish and operate a system for the collection or analysis of information in connection with the provision of health services and adult social care in England. The Government did not accept the recommendation that information functions previously held by the National Patient Safety Agency should be transferred to the Health and Social Care Information Centre. Instead, the key functions of the National Safety Patient Safety relating to	Hard Truths: The Journey to Putting Patients First: Volume Two	

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			the National Reporting and Learning System were transferred to NHS England.		
Improving patient safety	**258.**	The Information Centre should continue to develop and maintain learning, standards and consensus with regard to information methodologies, with particular reference to comparative performance statistics. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truthers report, the Government said that the Health and Social Care Information Centre published and kept under regular reviews its methodologies. It would adhere to principle four of the Code of Practice for Official Statistics and publish additional contextual data to help people use or interpret the data it published.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**259.**	The Information Centre, in consultation with the Department of Health, the NHS Commissioning Board and the Parliamentary and Health Service Ombudsman, should develop a means of publishing more detailed breakdowns of clinically related complaints. (February 2013)	This recommendation was accepted by the Government. In the February 2015 Culture Change report, the Government said that the Department of Health had worked with the Health and Social Care Information System to revise complaints data collection. Revised collections were to begin from April 2015. NHS Digital (the successor to the Health and Social Care Information Centre) publishes quarterly data on written complaints.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**260.**	The standards applied to statistical information about serious untoward incidents should be the same as for any other healthcare information and in particular the principles around transparency and accessibility. It would, therefore, be desirable for the data to be supplied to, and processed by, the Information Centre and, through them, made	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government said that responsibility for the reporting of patient safety incidents was transferred to NHS England in 2012 following the abolition of the National Patient Safety Agency. The Government referred to NHS England exploring the extent	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the	

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		publicly available in the same way as other quality related information. (February 2013)	to which information on serious incidents can be disclosed in more detail without breaching the Data Protection Act 1998. NHS England was also to consider the data standards applied to the National Reporting and Learning System to ensure, where appropriate, they are the same as those applied by the Health and Social Care Information Centre. In the February 2015 Culture Change report, the Government said that work to re-commission the National Reporting and Learning System was underway. The Government also said that monthly data on never event had been reported to the Strategic Executive Information System since April 2014.	Francis Inquiries: Supporting Annex	
Improving patient safety	**261.**	The Information Centre should be enabled to undertake more detailed statistical analysis of its own than currently appears to be the case. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths Report, the Government said that Health and Social Care Information had a role in undertaking high level analysis of data to support the interpretation of information prior to its publication, but that it would not prove local-level interpretative analysis. In the February 2015 Culture Change report, the Government said that the Health and Social Care Information Centre was reviewing its publications strategy to ensure that its outputs were providing relevant and useful statistics and analyses for customers and the public.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**262.**	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them:	This recommendation was accepted by the Government. The Government responded by stating that, rather than determining how local providers should meet their	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		(i) Effective real-time information on the performance of each of their services against patient safety and minimum quality standards. (ii) Effective real-time information of the performance of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment. (February 2013)	information needs centrally, the Department of Health would commit to connecting existing systems. Providers would set specific requirements locally but based on national standards to ensure that information could be shared across the system.		
Improving NHS culture and governance	**263.**	It must be recognised to be the professional duty of all healthcare professionals to collaborate in the provision of information required for such statistics on the efficacy of treatment in specialties. (February 2013)	This recommendation was accepted by the Government. However, the Government did not set out its position on how such a professional duty was to be envisaged or implanted.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**264.**	In the case of each specialty, a programme of development for statistics on the efficacy of treatment should be prepared, published, and subjected to regular review. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that mandate to the NHS Commissioning Board for April 2013 to March 2015 stated that the NHS should measure and publish outcome data for all major services by 2015, broken down by local clinical commissioning groups where patient numbers are accurate. This was to include	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the	

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			ensuring that data on services at speciality level was increasingly available. In June 2013, NHS England published specialities level data for cardiac surgery and vascular, and announced publication special for a further 8 specialties. The plan was to include other specialities over time, and the data published refreshed annually. In the February 2015 Culture Change report, the Government said that NHS England planned to publish consultant-level outcomes data from all appropriate NHS-funded national clinical audits before 2020.	Francis Inquiries: Supporting Annex	
Improving patient safety	**265.**	The Department of Health, the Information Centre and the Care Quality Commission should engage with each representative specialty organisation in order to consider how best to develop comparative statistics on the efficacy of treatment in that specialty, for publication and use in performance oversight, revalidation, and the promotion of patient knowledge and choice. (February 2013)	Accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the Healthcare Quality Improvement Partnership working with specialist associations to develop the specialist data from selected national clinical and medical audits. In the February 2015 Culture Change report, the Government referred to consultant-outcomes publications being made available through the NHS Choices website, with NHS England looking into which outcomes data could be most usefully and feasibly collected to extend the programme.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving patient safety	**266.**	In designing the methodology for such statistics and their presentation, the Department of Health, the Information Centre, the Care Quality Commission	This recommendation was accepted by the Government.	Hard Truths: The Journey to Putting	

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		and the specialty organisations should seek and have regard to the views of patient groups and the public about the information needed by them. (February 2013)	The Government accepted that initial development of speciality-level statistics had limited input from patient groups, but said NHS England would consider the role of service users in taking the programme forward.	Patients First: Volume Two	
Improving patient safety	**267.**	All such statistics should be made available online and accessible through provider websites, as well as other gateways such as the Care Quality Commission. (February 2013)	This recommendation was accepted by the Government. The data was made available through the NHS Choices website in 2014.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**268.**	Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry. (February 2013)	This recommendation was accepted by the Government. In its January 2014 Hard Truths report, the Government said that where collections were mandated, resources would be allocated to the providers as part of their overall budgets, by the relevant commissioning body via the NHS Standard Contract. It was the responsibility of all providers to ensure that resources are allocated internally to ensure that data are collected and made available as appropriate.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**269.**	The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said existing requirements for local audit of clinical records and external audit of clinical coding data would continue. The Health and Social Care information Centre would assess the extent to which the information it collected met the information standards and published its findings routinely. The Government also to the Health and Social Care Information Centre developing a National Data Quality	Hard Truths: The Journey to Putting Patients First: Volume Two	

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			Assurance Framework to outline data quality standards and compliance with them.		
Improving patient safety	**270.**	There is a need for a review by the Department of Health, the Information Centre and the UK Statistics Authority of the patient outcome statistics, including hospital mortality and other outcome indicators. In particular, there could be benefit from consideration of the extent to which these statistics can be published in a form more readily useable by the public. (February 2013)	This recommendation was accepted by the Government. The UK Statistics Authority undertook a review of patient outcome statistics recognised as official statistics, which was published in February 2014. The Secretary of State for Health then commissioned a further 7 sets of patient outcome statistics for independent UK Statistics Authority assessment, including Summary Hospital-level Mortality Indicator, which began in 2014.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex e.g. Patient Outcomes Statistics – Summary Hospital Level Mortality Indicator, SHMI, England – Office for Statistics Regulation	
Improving patient safety	**271.**	To the extent that summary hospital-level mortality indicators are not already recognised as national or official statistics, the Department and the Health and Social Care Information Centre should work towards establishing such status for them or any successor hospital mortality figures, and other patient outcome statistics, including reports showing provider-level detail. (February 2013)	This recommendation was by the Government, A report was published in July 2015 by the UK Statistics Authority and the Health and Social Care Information Centre which found that more work needed to be done before Summary Hospital-level Mortality Indicator could be designated as official statistics. It appears to now be so designated.	Hard Truths: The Journey to Putting Patients First: Volume Two Patient Outcomes Statistics – Summary Hospital Level Mortality	

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				Indicator, SHMI, England – Office for Statistics Regulation Summary Hospital-level Mortality Indicator (SHMI), Deaths associated with hospitalisation, England, November 2021 - October 2022	
Improving patient safety	**272.**	There is a demonstrable need for an accreditation system to be available for healthcare-relevant statistical methodologies. The power to create an accreditation scheme has been included in the Health and Social Care Act 2012, it should be used as soon as practicable. (February 2013)	Accepted by the Government. Cannot find any evidence this was implemented, either by the Health and Social Care Information Centre or its successor, NHS Digital.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Coroners and Inquests					
Improving patient safety	**273.**	The terms of authorisation, licensing and registration and any relevant guidance should oblige healthcare providers to provide all relevant information to enable the coroner to perform his function, unless a director is personally satisfied that withholding the information is justified in the public interest. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government agreed that relevant information should be shared with coroners to ensure they were able to perform their roles fully, but did not think this should be required in terms of registration of providers by the Care Quality Commission.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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Improving patient safety	**274.**	There is an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest. (February 2013)	This recommendation was accepted by the Government. The Government did not provide any details of what, if any guidance, was given	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**275.**	It is of considerable importance that independent medical examiners are independent of the organisation whose patients' deaths are being scrutinised. (February 2013)	This recommendation was accepted in principle by the Government. In the January 2014 Hard Truths report, the Government agreed that medical examiners needed to be independent of the deceased and their medical practitioner, but stated that to ensure that there were sufficient numbers of medical examiners to carry out their work, they would likely have some sort of professional relationship with local care regulations. As such, there would be no requirement to require that medical examiners are independent of the organisation whose patients' deaths are being scrutinised. From 1 April 2019, there was roll-out of a non-statutory system of medical examiners, whereby NHS trusts were encouraged to set up new medical examiner services to replace existing death certification processes. The Notification of Deaths Regulations 2019 came into force, providing statutory categorisation of the circumstances in which a medical practitioner was required to report a death to the coroner.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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			In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023.		
Improving patient safety	**276.**	Sufficient numbers of independent medical examiners need to be appointed and resourced to ensure that they can give proper attention to the workload. (February 2013)	This recommendation as accepted by the Government. The Government stated it was the responsibility of local authorities to ensure this was the case, but the Department of Health would provide each local authority with estimated numbers of medical examiners that may be required locally.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**277.**	National guidance should set out standard methodologies for approaching the certification of the cause of death to ensure, so far as possible, that similar approaches are universal. (February 2013)	This recommendation was accepted by the Government. Guidance was first published in September 2018.	Hard Truths: The Journey to Putting Patients First: Volume Two Guidance for doctors completing medical certificates of cause of death in England and Wales	
Improving patient safety	**278.**	It should be a routine part of an independent medical examiner's role to seek out and consider any serious untoward incidents or adverse incident reports relating to the deceased, to ensure that all circumstances are taken into account whether or not referred to in the medical records. (February 2013)	This recommendation was accepted by the Government. In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023.	Hard Truths: The Journey to Putting Patients First: Volume Two	

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Improving patient safety	**279.**	So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment. (February 2013)	This recommendation was accepted by the Government. Current guidance states that it is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified.	Hard Truths: The Journey to Putting Patients First: Volume Two Death Certification Regulations Guidance for doctors completing medical certificates of cause of death in England and Wales (accessible version)	
	280.	Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner. (February 2013)	This recommendation was accepted by the Government. The Government published draft death certification regulations requiring medical examiners to make arrangements to speak to anyone they consider necessary to discuss the circumstances and causes of death and to provide them with the opportunity to mention any matter that might cause a senior coroner to think that the death should be investigated. These regulations were not implemented. In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023.	Hard Truths: The Journey to Putting Patients First: Volume Two Death Certification Regulations	

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	281.	It is important that independent medical examiners and any others having to approach families for this purpose have careful training in how to undertake this sensitive task in a manner least likely to cause additional and unnecessary distress. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the Royal College of Pathologists and e-Learning for Healthcare producing an online learning course, including a module on interacting with the bereaved. In April 2023, the Government announced it intended to introduce a statutory medical examiner system from April 2024. Primary legislation by way of amendment of the Coroners and Justice Act 2009 to provide the framework for this came into force in October 2023.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving patient safety	**282.**	Coroners should send copies of relevant Rule 43 reports to the Care Quality Commission. (February 2013)	This recommendation was accepted by the Government. The Government said in the January 2014 Hard Truths report that the Care Quality Commission already received prevention of future death reports. The Coroners' Society of England and Wales agreed for coroners to provide the Care Quality Commission with copies of any Regulation 28 report and require a response where concerns about care or treatment provided by a registered provider have been identified during or at the conclusion of the inquest.	Hard Truths: The Journey to Putting Patients First: Volume Two mou cqc and csocew_final_with_pagnination_and_numbered_paragraphs	
	283.	Guidance should be developed for coroners' offices about whom to approach in gathering information about whether to hold an inquest into the death of a patient. This should include contact with the patient's family. (February 2013)	This recommendation was accepted by the Government. In the 2015 Culture Change report, the Government said that the Judicial College had in place a programme of mandatory coroner training in place for 2013-14, with a	Hard Truths: The Journey to Putting Patients First: Volume Two	

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			programme of annual continuation training for coroner beginning in April 2014.		
	284.	The Lord Chancellor should issue guidance as to the criteria to be adopted in the appointment of assistant deputy coroners. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Ministry of Justice and the Chief Coroner had published guidance titled 'The Appointment of Coroners' in July 2013, which specified details for the appointment of assistance coroners based on the main process for senior coroners.	Hard Truths: The Journey to Putting Patients First: Volume Two	
	285.	The Chief Coroner should issue guidance on how to avoid the appearance of bias when assistant deputy coroners are associated with a party in a case. (February 2013)	This recommendation was accepted by the Government. Bias guidance was issued by the Chief Coroner in September 2014.	Hard Truths: The Journey to Putting Patients First: Volume Two Chief Coroner Guidance No.15 - Bias (judiciary.uk)	
Department of Health Leadership					
Improving NHS culture and governance	**286.**	Impact and risk assessments should be made public, and debated publicly, before any proposal for any major structural change to the healthcare system is accepted. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government stated that it was good practice for all major changes of police and of system structure to be carefully considered.	Hard Truths: The Journey to Putting Patients First: Volume Two	
Improving NHS culture and governance	**287.**	The Department of Health should together with healthcare systems regulators take the lead in developing through obtaining consensus between the public and healthcare professionals, a coherent, and easily accessible structure for the development	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said that the Care Quality Commission had consulted on the fundamental standards of care, and that attention would	Hard Truths: The Journey to Putting Patients First: Volume Two	

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		and implementation of values, fundamental, enhanced and developmental standards as recommended in the report. (February 2013)	be given to how they are provided to providers and the public. The concept of enhanced standards was to be represented by the existing quality standards developed by the National Institute for Health and Care Excellence, with developmental statements to be included where appropriate. The Care Quality Commission's three Chief Inspectors were to engage with the public, providers and professionals to develop guidance to make it clear what compliance with the regulations involved and how it joined up with other rights, entitlements and standards. Th Government said it had revised the NHS Constitution was revised to give greater prominence to NHS values. In the February 2015 Culture Change report, the Government said the Department of Health had consulted on the fundamental standards regulations between January and April 2014, and the Care Quality Commission had consulted on proposed guidance on meeting the regulations in July 2014. The Government also said the Care Quality Commission had published a series of provider handbooks to sit alongside the guidance on the regulations.	Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**288.**	The Department of Health should ensure that there is senior clinical involvement in all policy decisions which may impact on patient safety and well-being. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government said the Department of Health had put in place arrangements to ensure access to clinical advice, including direct employment of clinical advisers where appropriate,	Hard Truths: The Journey to Putting Patients First: Volume Two	

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			access to advice from senior clinicians elsewhere in the system, and a programme of connecting to front-line practitioners and organisations.		
Improving NHS culture and governance	**289.**	Department of Health officials need to connect more to the NHS by visits, and most importantly by personal contact with those who have suffered poor experiences. The Department of Health could also be assisted in its work by involving patient/service user representatives through some form of consultative forum within the Department. (February 2013)	This recommendation was by the Government. In the January 2014 Hard Truths report, the Government said a major programme had been established within the Department of Health to ensure that staff throughout the organisation were given the opportunity to experience front-line realities, including by civil servants spending time with a wide range of health and care organisations. In the February 2015 Culture Change report, the Government said that in the first year of the programme, over 2,000 connecting days had taken place involving over 500 staff.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	
Improving NHS culture and governance	**290.**	The Department of Health should promote a shared positive culture by setting an example in its statements by being open about deficiencies, ensuring those harmed have a remedy, and making information publicly available about performance at the most detailed level possible. (February 2013)	This recommendation was accepted by the Government. In the January 2014 Hard Truths report, the Government referred to the various measures it had put in place to increase transparency in the NHS, including the duty of candour.	Hard Truths: The Journey to Putting Patients First: Volume Two Culture Change in the NHS -Applying the lessons of the Francis Inquiries: Supporting Annex	

17 THE BERWICK REVIEW INTO PATIENT SAFETY

17.1 Introduction

The Berwick review into patient safety followed the Francis review and studied the various accounts of Mid Staffordshire, as well as the recommendations of Robert Francis QC and others, to distil for Government and the NHS the lessons learned, and to specify the changes that are needed. Professor Don Berwick, an international expert in patient safety, was asked by the Prime Minister to carry out the review following the publication of the Francis Report into the breakdown of care at Mid Staffordshire Hospitals.

The report was published in August 2013 and is entitled “A promise to learn – a commitment to act: Improving the safety of patients in England’. The report can be viewed online.

The government jointly responded to the Francis review, the Berwick review, and a number of other inquiries / reviews which had been commissioned at a similar time, in ‘Hard Truths: the journey to putting patients first’, which was published in January 2014 in two volumes. Annex C of Volume One of the report specifically addresses the Berwick review. The Government accepted the 10 overarching recommendations.

17.2 Berwick Review: Table of Recommendations

Berwick Review					
Type of recommendation	No.	Details of Recommendation	Implementation	Source	Level of Assessment
I. The overarching goal					
Improving patient safety	**1**	The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning. (August 2013) Key points: • Quality of patient care and patient safety should come before all other considerations. • Aspire for continual reduction of harm. • Quantitative targets and financial goals should not override protection of patients from harm…Where scarcity of resources threatens to compromise safety, all NHS staff should raise concerns to their colleagues and superiors and be welcomed in so doing.	Accepted by the government. (January 2014) 'The review called for the Government and NHS leaders to state the primacy of safety and quality as the aims of the NHS. The Government has restated this commitment in its further response to Francis.' A number of key actions were committed to by the government – see page 121 of the Government Response. They are set out in the below sections to which they are most relevant but may apply across the recommendations. The NHS committed to patient-centred culture change as a key part of the Five Year Forward View plans put forward by NHS England. Over 200 NHS organisations have joined the Sign Up To Safety campaign committing to halve avoidable harm and save 6,000 lives by 2017. (February 2015)	**'Hard Truths: The Journey to Putting Patients First' Government response to Francis, Berwick and other reviews** (Published January 2014) **NHS Five Year Forward View** (October 2014) **Government Oral Statement to Parliament** (February 2015)	
II. Leadership					

Berwick Review					
Improving patient safety **Regulation and oversight of NHS managers**	**2**	All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support. (August 2013) **Key actions:** All staff and leaders of NHS-funded organisations: • Identify and help to reduce risks to safety of patients. • Ensure that there is the environment, resources, and time to enable staff to acquire the skills necessary to do so. • Actively address poor teamwork and poor individual practices. NHS England: • Designate a set of safety-leadership behaviours that can be used in leaders' hiring, in appraisals, in leadership development, and in promotion. See Box 1 (page 17) of the report for further detail. Leadership bodies of NHS-funded organisations: • Define strategic aims in patient safety, and should regularly review data and actions on quality, patient safety and continual improvement at their Board or leadership meetings. • Employ structures and processes to engage regularly and fully with patients and carers, to understand their perspectives on and contributions to patient safety.	Accepted by the government. (January 2014) As above.	**'Hard Truths: The Journey to Putting Patients First' Government response to Francis, Berwick and other reviews** (Published January 2014)	

Berwick Review					
		Prime Minister and Government: • Hold final responsibility for fostering a climate that supports learning and continual improvement. Government and NHS organisations: • Help patient representatives and community champions to become safety leaders, in part by offering them the opportunity to learn safety-leadership behaviours and skills. Local Government Association: • Take lead responsibility for promoting better integration of the boundaries between health and social care in the interests of patient safety and encouraging local government to fulfil its scrutiny role effectively			
III. Patient and public involvement					
Improving patient safety	**3**	Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts. The patient voice should be heard and heeded at all times. (August 2013) **Key actions:** All NHS organisations • Patients and their carers should be helped to establish effective relationships with their clinicians at every stage of their care, from GP surgery to hospital ward. (For example, there should be clear information about who is working on the ward and who will be	Accepted by the government. (January 2014) The Department of Health has agreed with the nursing and medical Royal Colleges and clinical leaders that every hospital patient should have the name of the consultant and nurse responsible for their care above their beds. The Government also intends to introduce a named accountable clinician for people receiving care outside hospitals, starting with vulnerable older people. Clinical commissioning groups will be commissioning support for patients' participation and decisions in relation to their own care and patient and public involvement will be at the heart of commissioning, with at least two lay members on commissioning groups governing bodies.	**'Hard Truths: The Journey to Putting Patients First' Government response to Francis, Berwick and other reviews** (Published January 2014)	

Berwick Review					
		each patient's primary nurse that day and night.) • Patients and (if the patient wishes) their carers should be involved as much as possible in their care planning. (For example, carers should be invited to and involved in ward rounds, multi-disciplinary meetings, Care Programme Approach meetings, discharge planning meetings and other significant clinical meetings.) • Patients and their carers should always have access to and be given on request a clear, understandable and relevant summary of their health needs and preferences, which states how these needs will be met. This should include information about risks and alternatives and should allow them greater control of their healthcare. • Patients and their carers should be represented throughout the governance structures of NHS-funded healthcare providers, e.g. sitting on safety/quality committees, ad given appropriate support and training to take part fully in these structures. <u>All NHS staff</u> • Patients and their carers should always be given the opportunity to share their health concerns, histories, family situations, needs, preferences and hopes in order to	At a national level, the Care Quality Commission is now involving patients in its inspections to inform its ratings of hospitals. Trust Chief Executives and Boards will be expected to take personal responsibility for complaints, for example by signing off letters and through an update at each board meeting. Detailed information on complaints and the lessons learned will be published quarterly. (January 2014)		

Berwick Review					
		help staff build effective partnerships during every stage of their care. Commissioners and providers • NHS England, CCGs and provider organisations should ensure that a specific, named and recognised clinician, known to the patient, is responsible for the coordination of care for every patient at every phase of treatment regardless of setting. Leaders of NHS organisations • It should always be clear who is responsible for patient safety concerns, and someone should be accessible to patients at every stage of treatment and 24 hours a day. When things do go wrong, incidents should be investigated appropriately and transparently, with the full involvement of the patient and their carers. • Patient feedback is instrumental to safety and should be collected as far as possible in real time, and responded to as quickly as possible. Government • Further consideration of an independent national complaints management system that is easy to access and use, and that would also highlight and promote better practice and improvements in the NHS. • Separate work is ongoing to look at the NHS complaints system.			

Berwick Review					
IV. Staff					
Improving patient safety **Improving the ability to raise complaints and concerns**	**4**	Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported. (August 2013) **Key actions:** National Institute for Care Excellence • Interrogate the available evidence for establishing what all types of NHS services require in terms of staff numbers and skill mix to assure safe, high quality care. All leaders of NHS-funded provider organisations • Staffing levels should be consistent with the scientific evidence on safe staffing, adjusted to patient acuity and the local context. Conclusions should be public and easily accessible to patients, carers and regulators. Health Education England, Government and NHS England • Health Education England should assure that they have commissioned the required training places to meet future staffing requirements working with Government and NHS England to ensure appropriate planning and resources. All leaders and managers of NHS-funded provider organisations • Foster good teamwork in care.	Accepted by the government. (January 2014). The National Quality Board and the Chief Nursing Officer are publishing a guidance document that sets out the current evidence on safe staffing. The most recent version of the guidance is dated July 2016. By Summer 2014, the National Institute of Health and Care Excellence will produce independent and authoritative evidence based guidance on safe staffing, and will review and endorse associated tools for setting safe staffing levels in acute settings. The National Institute for Health and Care Excellence will then start work to develop similar guidance and endorsement for staffing in non-acute settings, including mental health, community and learning disability services. The guidance was subsequently published on 15 July 2015. From April 2014, and by June 2014 at the latest, NHS Trusts will publish ward level information on whether they are meeting their staffing requirements. Actual versus planned nursing and midwifery staffing will be published every month; and every six months Trust boards will be required to undertake a detailed review of staffing using evidence-based tools. Appropriate staffing levels will be a core element of the Care Quality Commission's registration regime. The Department of Health has commissioned a programme of work from NHS Employers that will provide tools and training for employers to support the engagement, health and well-being of their staff. The Secretary of State has made clear that so-called 'gagging orders' are unacceptable. NHS staff will be able to raise concerns about patient care in the knowledge that	**'Hard Truths: The Journey to Putting Patients First' Government response to Francis, Berwick and other reviews** (Published January 2014) **Health Education England Shape of Caring Review:** Published March 2015 <link> **National Institute of Health and Care Excellence (NICE) Guidance on Safe Staffing**: Published July 2014 **National Quality Board guidance on safe staffing:** July 2016	

Berwick Review					
		• Actively support staff. • Create systems for supportively assessing the performance of all clinical staff, building on the introduction of medical revalidation. • Each organisation should be expected to listen to the voice of staff, such as through department and ward level cultural and teamwork safety surveys, to help monitor the safety and quality of care and variation among units. Staff should all be free to state openly their concerns about patient safety without reprisal. (No use of 'gagging orders'). Also see Box 3 (page 23) for actions suggested for frontline staff.	they will be listened to and their views will be welcomed. The new Chief Inspector of Hospitals will be judging whether the culture of the organisation actively promotes the benefits of openness and transparency; and staff can now blow the whistle to their health and care professional regulatory bodies. All healthcare professionals will be protected by the provisions of the Public Interest Disclosure Act 1998. (January 2014) There are also a number of proposed actions by the government regarding ensuring staff are trained and motivated – see page 20 of the government response for further detail. Health Education England published the Shape of Caring review in March 2015, providing recommendations to ensure that throughout their careers nurses and care assistants receive consistent high-quality education and training which supports high quality care over the next 15 years.		
V. Training and capacity building					
Improving patient safety	**5**	Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives. (August 2013) **Key actions:** Training and Education regulators, providers and Health Education England • The commissioners, regulators and providers of training and education for healthcare professionals (including clinicians, managers, Boards and relevant Governmental staff and leaders) should	Accepted by the government. (January 2014) The NHS Leadership Academy and Health Education England will be investing in education and training programmes to ensure that safety is embedded in leadership programmes and other post graduate training programmes for professionals. (January 2014)	**'Hard Truths: The Journey to Putting Patients First' Government response to Francis, Berwick and other reviews** (Published January 2014)	

Berwick Review					
		ensure that all healthcare professionals 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. See also actions in 6, below, as relevant.			
Improving patient safety	**6**	The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS. (August 2013) **Key actions:** <u>Education, regulators, providers and Health Education England</u> • Continue and build upon work to date to ensure that medical and nursing undergraduates and postgraduates are conversant with and skilful at patient safety / quality improvement. <u>NHS England and partners</u> • Encourage and expand structured programmes to equip NHS leaders with an in-depth understanding of safety and improvement, and of managing the spread of innovations and good ideas. <u>All NHS organisations</u> • Invest in building capability within their organisations to enable staff to contribute to improvement of the quality and safety of services to patients. See Box 4 (page 26)	Accepted by the government. (January 2014) The NHS Leadership Academy and Health Education England will be investing in education and training programmes to ensure that safety is embedded in leadership programmes and other post graduate training programmes for professionals. NHS England is working with NHS Improving Quality to develop proposals for the establishment of a network of Patient Safety Collaboratives across England. The aim of the Collaboratives is to create a comprehensive, effective, and sustainable improvement system that will deliver a culture of continual learning and improvement in patient safety across the country over the next five years. The design, support and recruitment of participating organisations is planned to be delivered by spring 2014. The programme will also include establishing a Patient Safety Improvement Fellowship scheme to develop 5,000 Fellows within a national faculty within five years. (January 2014)	**'Hard Truths: The Journey to Putting Patients First' Government response to Francis, Berwick and other reviews** (Published January 2014)	

Berwick Review					
		for the expected capability programme which must be in place in 12 months. • Each organisation should participate in one or more collaborative improvement networks. NHS England and government • NHS England should be given the resources to support and learn from existing collaborative safety improvement networks and to sponsor the development of new regional or sub-regional collaborative networks across the country. NHS England • Improvement networks should include processes for monitoring and evaluation by the networks together with NHS England. • Organise a national system of NHS Improvement Fellowships. See also actions in 5, above, as relevant.			
VI. Measurement and transparency					
Improving patient safety	**7**	Transparency should be complete, timely and unequivocal. All non-personal data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public. (August 2013) **Key actions:** All healthcare system organisations	Accepted by the government. (January 2014) NHS England and the Care Quality Commission are committed to working together to develop a shared and agreed approach to measuring safety in the NHS, both for regulatory and improvement purposes. The organisations are working to develop a set of patient safety measures that are best suited for use by the Care Quality Commission in their surveillance model, and NHS England is providing patient safety expertise on how patient safety data might be used for surveillance and inspection.	**'Hard Truths: The Journey to Putting Patients First' Government response to Francis, Berwick and other reviews** (Published January 2014)	

Berwick Review					
		• Share all data on quality of care and patient safety that is collected with anyone who requests it, in a timely fashion, with due protection for individual patient confidentiality. <u>Commissioners</u> • Increase funding for NHS organisations to analyse and effectively use safety and quality information <u>NHS-funded healthcare providers</u> • Shift away from their reliance on external agencies as the guarantors of safety and quality and toward proactive assessment and accountability on their own part. • Make use of peer review outside of formal systems – for example by partnering with other organisations – to facilitate learning <u>All NHS organisations</u> • Unless and until a better metric is developed, the NHS should use mortality rate indicators like the Hospital Standardised Mortality Rate or suitable alternatives as one of its ways to detect potentially severe performance defects worth investigating further. • Routinely collect, analyse and respond to local measures that serve as early warning signals of quality and safety problems such as the voice of the patients and the staff, staffing levels, the reliability of critical processes and other quality metrics. <u>All NHS-funded provider organisations</u>	NHS England will be publishing never events quarterly before the end of 2013 and monthly by April 2014, and is exploring ways to make safety thermometer data more accessible to the public. NHS England is leading on work to develop a single and agreed methodology for retrospective case note reviews undertaken by Trusts. (January 2014) The Care Quality Commission and NHS England will work with Monitor, Trust Development Authority, the Information Centre and others to make patient safety data more accessible to all and provide clear guidance on what it means – and does not mean. This includes issuing a joint statement from the Care Quality Commission and NHS England on their commitment to complete alignment of patient safety measurement and developing a dedicated hospital safety website for the public which will draw together up to date information on patient safety factors, for which robust data is available. This will include information on staffing, pressure ulcers, healthcare associated infections and other key indicators, where appropriate at ward level. The website will aim to begin publication from June 2014. (January 2014) Trusts will continue to be encouraged to use NHS Safety Thermometer data collection to help inform improvements in some key patient safety areas: pressure ulcers, falls resulting from harm, catheter-associated infections and venous thromboembolism. (January 2014) NHS England will begin to publish ‘never events’ data quarterly before the end of 2013, and then monthly from April 2014.		

Berwick Review					
		• In addition to reporting aggregated data for the whole organisation, data on fundamental standards and other reportable measures, as required by CQC, should be reported by each ward, clinical department (and health care professional, where appropriate) within the Trust's Annual Quality Account. See also actions in 8, below, as relevant.			
Improving the ability to raise complaints and concerns **Improving patient safety**	**8**	All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care. (August 2013) **Key actions:** <u>All healthcare system organisations</u> Include patient voice as an essential resource for monitoring and improving the safety and quality of care. See also recommendations in 7, above, as relevant.	Accepted by the government. (January 2014) The NHS Constitution sets out in one place the rights that all patients should expect when they receive care, and which govern how NHS organisations must behave. Following successful implementation in acute hospitals, the use of the friends and family test will be extended to mental health settings by the end of December 2014. This will allow patients and staff the chance to raise concerns about standards of care in their hospitals, quickly and effectively. In February 2015 the friends and family test was also rolled out to primary care. By December of this year 80% of clinical commissioning groups will be commissioning support for patients' participation and decisions in relation to their own care. At a national level, the Care Quality Commission is now involving patients in its inspections to inform its ratings of hospitals.	**'Hard Truths: The Journey to Putting Patients First' Government response to Francis, Berwick and other reviews** (Published January 2014) **Government Oral Statement to Parliament** (February 2015)	
VII. Structures and regulation					
Improving patient safety	**9**	Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of	Accepted by the government. (January 2014) There are new arrangements for inspection and regulation in terms of quality and safety and a commitment by system	**'Hard Truths: The Journey to Putting Patients First' Government**	

Berwick Review					
		staff. All incentives should point in the same direction. (August 2013) **Key actions:** <u>Care Quality Commission and NHS England</u> • Care Quality Commission should hold Boards responsible for ensuring that recommendations from patient safety alerts are implemented promptly. NHS England should complete the re-design and implementation of a patient safety alerting system for the health care system in England. Care Quality Commission should assure that organisations respond effectively to these alerts except in the rare circumstances where organisations can demonstrate that implementation of an alert is not in the interests of specific patient groups. <u>Care Quality Commission, Monitor and the Trust Development Authority</u> • Commit to seamless, full, unequivocal, visible and whole-hearted cooperation with each other and with all other organisational and professional regulators, agencies and commissioners. <u>Government</u> • Continually review scope of above cooperation and act immediately and decisively if it fails. • An in-depth, independent review of structures and the regulatory system should be completed by the end of 2017,	and professional regulators to cooperate in the sharing of information and concerns. (January 2014) NHS England will re-launch the patient safety alerts system by the end of 2013 in a clearer framework that will support organisations to understand and take rapid action in relation to patient safety risks. (January 2014) The Care Quality Commission has introduced meaningful ratings – outstanding, good, requires improvement, or inadequate. Trusts aspiring to Foundation Trust status will have to achieve 'good' or 'outstanding' under the Care Quality Commission's new inspection regime to be authorised. Monitor and the Care Quality Commission will also implement a joint registration and licensing system in April 2014. The Care Quality Commission was provided with legal independence and new legal powers (February 2015). Where a Foundation Trust is placed in special measures, it will have its freedom to operate as an autonomous body suspended. (January 2014) Monitor, the Trust Development Authority, and the Care Quality Commission agreed a new Memorandum of Understanding in February 2015 about the special measures process. In October 2013, Monitor introduced a Risk Assessment Framework for NHS Foundation Trusts which will allow Monitor to track risk and trigger enforcement action.	**response to Francis, Berwick and other reviews** (Published January 2014) **Memorandum of Understanding between Monitor, the Trust Development Authority, and the Care Quality Commission** (February 2015) **Monitor's Risk Assessment Framework** (Published August 2013; last updated August 2015)	

Berwick Review					
		once current proposed changes have been operational for three years (See Box 6, page 32). • Develop plans to allow for the permanent disqualification from relevant positions in the NHS of those at Director level or equivalent whose criminal liability is proven. This sanction is not to be used if someone is struggling in their current position or is facing intractable problems in achieving success. It is a sanction reserved for the worst conduct, and its availability as a sanction should act as a deterrent. • Ensure it is possible for healthcare support workers to receive training and development in order to meet clear codes of practice. <u>Regulators, Health Education England, professional societies, commissioners</u> • Streamline requests for information from providers so that they have to provide information only once and in unified formats. <u>Care Quality Commission</u> • Develop the "fundamental standards" recommended by Robert Francis, using a process involving patients, carers and the public. <u>NHS England</u> • Promptly coordinate the development of an explicit description of the systems of oversight and controls of quality and safety			

Berwick Review					
		relevant to different types of provider organisations, identify any vulnerabilities in those systems, and, working with others, take action to correct them.			
VIII. Enforcement					
Improving patient safety	**10**	We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment. (August 2013) **Key actions:** <u>Government</u> • Create a new general offence of wilful or reckless neglect or mistreatment applicable both to organisations and individuals. • It is absolutely vital that any new legislation avoid criminalising unintended errors. An individual should not be convicted of this new offence unless it can be shown the failure was the fault of the individual alone and the individual was acting in a reckless or wilful manner. Liability should be proportionate to past conduct for both individuals and organisations. • Make it an offence for a healthcare organisation to withhold or obstruct the provision of relevant information to a commissioner, regulator, inspector, coroner or other person with a legitimate duty in relation to quality and safety of care.	Accepted by the government. (January 2014) The review confirmed the Government's plans to introduce a new statutory duty of candour on providers. The Government is working with the professional regulators to strengthen the references to candour in professional regulation. The Government will also seek to introduce a new criminal sanction that covers wilful neglect designed for those guilty of the most extreme types of poor care. (January 2014) The offences regarding wilful neglect were introduced via the Criminal Justice and Courts Act 2015, ss.20-25. The statutory duty of candour was introduced in October 2014, following a consultation which concluded in March 2014. Where the NHS Litigation Authority finds that a Trust has not been open with patients or their families about a patient safety incident which turns into a claim, it could have the discretion to reduce or remove that Trust's indemnity cover for that claim. The NHS Litigation Authority will continue to make compensation payments due to patients. In addition to the statutory duty of candour on providers, there is also a professional duty of candour on individuals that will be strengthened. Subject to Parliament, the Care Bill proposes a new criminal offence applicable to care providers who supply, publish or otherwise make available certain types of information that is false or misleading, where that	**'Hard Truths: The Journey to Putting Patients First' Government response to Francis, Berwick and other reviews** (Published January 2014) **Statutory Duty of Candour:** Introduced in October 2014 **Consultation on statutory duty of candour:** Concluded March 2014 **Criminal Justice and Courts Act 2015** **Care Act 2014**	

Berwick Review					
		• See Box 7 (page 35) for suggested liability criteria for criminal sanctions. • We do not support the creation of a statutory duty for healthcare workers to report beliefs or suspicions about serious incidents to their employer, as this duty is adequately addressed in relevant professional codes of conduct and guidance. <u>Government and Care Quality Commission</u> • Where an incident qualifying as a Serious Incident (as defined by NHS England) occurs, Care Quality Commission regulations should require that the patient or carers affected by the incident be notified and supported. We do not subscribe to an automatic 'duty of candour' where patients are told about every error or near miss, as this will lead to defensive documentation and large bureaucratic overhead that distracts from patient care. However, patients should be given all the information they ask for. <u>NHS-funded provider organisations and professional regulators</u> • Employers need to improve their support of staff around implementing guidance on reporting of serious incidents and professional regulators should take appropriate action when required. Organisations should demonstrate that they have in place fully functional reporting	information is required to comply with a statutory or other legal obligation. The Bill also proposes that this offence will apply to the 'controlling minds' of the organisation, where they have consented or connived in an offence committed by a care provider. (January 2014) The offence of care providers publishing false or misleading information was introduced in the Care Act 2014, s.92(1). The government confirmed it does accept Professor Don Berwick's recommendation that we should avoid an automatic duty of candour where patients are told of every error or near miss. A consultation was commissioned about the threshold for duty of candour (January 2014) to be completed by David Dalton and Professor Norman Williams.		

Berwick Review					
		systems for serious incidents, that staff know how to use them, that the systems are used, and that appropriate action is taken in response to incidents, including provision of appropriate support to the affected patients and their carers.			

18 INDEPENDENT OVERSIGHT OF NHS AND DEPARTMENT OF HEALTH INVESTIGATIONS INTO MATTERS RELATING TO JIMMY SAVILE

18.1 Introduction

This report was commissioned by the Secretary of State for Health to provide independent oversight of 3 independent investigations into the role of Jimmy Savile in the NHS and general oversight of the smaller investigations. The author of the report was Kate Lampard. Her assurance report provides assurance of 28 reports published in June 2014, including the independent investigations at Broadmoor Hospital and Leeds General infirmary. The intent was to ensure that an independent person was satisfied that the Government and the relevant NHS organisations were taking a sufficiently robust process to establish the truth and protect the interests of patients. The conclusion was the NHS investigations completed to date, as of June 2014, into matters relating to Jimmy Savile have been conducted in an appropriate and robust fashion and that the resulting reports should be published.

The report was published in June 2014. The report can be viewed online.

A further 'Themes and lessons learnt' document was published in February 2015, authored by Kate Lampard and Ed Marsden, which draws on the findings and conclusions of the NHS investigations to make recommendations to strengthen patient care and safety.

The Government (the Department of Health; now the Department of Health and Social Care) accepted 13 out of the 14 recommendations in February 2015. In response to the 'Lessons learnt' document, the government provided a further document in November 2015 which had gathered and collated responses from all NHS Trusts and Foundation Trusts as to plans and actions taken since the report.

18.2 Independent Oversight into the Role of Jimmy Savile in the NHS: Table of Recommendations

Independent Oversight into the Role of Jimmy Savile in the NHS					
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
Improving patient safety	**R1**	All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception. (February 2015)	**Government response: accepted in principle. (November 2015)** In June 2015 NHS Employers published information which outlines the key considerations for employers when devising, implementing and reviewing local arrangements targeted at managing official visits on NHS premises. 41% of trusts (both NHS trusts and foundation trusts) have a dedicated policy in place. A further 55% committed to either develop a new policy or strengthen existing informal arrangements by September 2015. The remaining providers planned to implement later in 2015-16.	**Government response document, 'Jimmy Savile NHS investigations: Update on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'** Published November 2015	
Improving patient safety	**R2**	All NHS trusts should review their voluntary services arrangements and ensure that: • they are fit for purpose; • volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and	**Government response: accepted in principle. (November 2015)** 51% of providers confirmed that, having undertaken a review of their services, they had a fit for purpose procedure in place to manage the recruitment, development and training of their cohort of volunteers. A number of trusts identified that they require volunteers to	**Government response document, 'Jimmy Savile NHS investigations: Update on the**	

Independent Oversight into the Role of Jimmy Savile in the NHS					
Regulation and oversight of NHS managers		• all voluntary services managers have development opportunities and are properly supported. (February 2015)	follow similar on-boarding practices as employees, including Trust induction and training. The majority of remaining trusts had committed to or had started to undertake reviews of their services – with 39% committing to complete this by September 2015, and the remainder of providers doing so after this.	**themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'** Published November 2015	
Regulation and oversight of NHS managers	**R3**	The Department of Health and NHS England should facilitate the establishment of a properly resourced forum for voluntary services managers in the NHS through which they can receive peer support and learning opportunities and disseminate best practice. (February 2015)	**Government response: accepted in principle. (November 2015)** To help strengthen the volunteer service managers network structure, NHS England will join the National Association of Volunteer Service Managers which has existed for 47 years to support volunteer management in the NHS and healthcare. Working in partnership with National Association of Volunteer Service Managers and other volunteer networks and organisations they will encourage further sharing of best practice in volunteer development, management and support as well as developing a quality assurance scheme for NHS Trusts and healthcare organisations. This will promote the importance of having well trained and resourced volunteer service managers in all NHS Trusts and other NHS and healthcare organisations.	**Government response document, 'Jimmy Savile NHS investigations: Update on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'** Published November 2015	
Improving patient safety	**R4**	All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in	**Government response: accepted in principle. (November 2015)**	**Government response document, 'Jimmy Savile**	

Independent Oversight into the Role of Jimmy Savile in the NHS					
		safeguarding at the appropriate level at least every three years. (February 2015)	Over half of trusts (51%) reported that appropriate safeguarding training, renewable on at least three yearly basis, is in place for both staff and volunteers. A further 35% of trusts have committed to put this training in place for both staff and volunteers by September, with the remainder planning to do so at a later date.	**NHS investigations: Update on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'** Published November 2015	
Improving patient safety	**R5**	All NHS hospital trusts should undertake regular reviews of: • their safeguarding resources, structures and processes (including their training programmes); and • the behaviours and responsiveness of management and staff in relation to safeguarding issues; to ensure that their arrangements are robust and operate as effectively as possible. (February 2015)	**Government response: accepted in principle. (November 2015)** 65% of trusts identified as already being compliant with this recommendation. A further 26% stated this will be completed by September 2015, with the remainder planning to be compliant later in 2015-16.	**Government response document, 'Jimmy Savile NHS investigations: Update on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'** Published November 2015	
Improving patient safety	**R6**	The Home Office should amend relevant legislation and regulations so as to ensure that all hospital staff and volunteers undertaking work or volunteering	**Government response: not accepted. (November 2015)**	**Government response document,**	

Independent Oversight into the Role of Jimmy Savile in the NHS					
		that brings them into contact with patients or their visitors are subject to enhanced Disclosure and Barring Service and barring list checks (February 2015)	In his statement on 26 February, the Secretary of State agreed that all volunteers working in regulated activity—typically close or unsupervised contact with patients—should have an enhanced Disclosure and Barring Service check. He reiterated the Government position on Disclosure and Barring Service checks and urged Trusts to take a considered approach, including the use of enhanced Disclosure and Barring Services where volunteers may work closely with patients in the future. NHS Employers will continue to support organisations to understand and meet the legal and mandated requirements to undertake employment checks, including those required as part of the Disclosure and Barring Service regime.	**'Jimmy Savile NHS investigations: Update on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'** Published November 2015	
Improving patient safety	**R7**	All NHS hospital trusts should undertake Disclosure and Barring Service checks (including, where applicable, enhanced Disclosure and Barring Service and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers. (February 2015)	**Government response: accepted in principle. (November 2015)** This reply had the greatest variety of responses from trusts, with providers relatively evenly split in their responses between those providers who either: • have, or will, adopt Disclosure and Barring Service refresher checks every 3 years; • are reviewing internally their processes; • do not undertake regular Disclosure and Barring Service refresher checks; or	**Government response document, 'Jimmy Savile NHS investigations: Update on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'** Published November 2015	

Independent Oversight into the Role of Jimmy Savile in the NHS					
			• were waiting for further guidance from NHS Employers (or the Department of Health) before making any amendments to their current policy. The NHS Employers website was updated in April 2015 to provide further clarity about the current requirements for employers, to address the last point. The guidance makes clear that there is no legal requirement for employers to undertake three yearly checks; but that the frequency period should remain determinable by any risks identified by employers at a local level as opposed to being prescribed at a national level. The guidance also makes clear that Trusts can ensure that their information on volunteers is up to date through asking volunteers to make use of the Disclosure and Barring Service update service. The Department of Health will continue to work with NHS Employers and NHS England in light of this recommendation to consider what more can be done to support employers to understand their legal duties.		
Improving patient safety	**R8**	The Department of Health and NHS England should devise and put in place an action plan for raising and maintaining NHS employers' awareness of their obligations to make referrals to the local authority designated officer (LADO) and to the Disclosure and Barring Service. (February 2015)	**Government response: accepted in principle. (November 2015)** The Department of Health already works with NHS Employers to ensure that employers are aware of their obligations in this area. NHS Employers already provide extensive information about duties for employers to make referrals to the DBS. The Department of Health will continue to work with NHS Employers and NHS England in light of trusts responses to	**Government response document, 'Jimmy Savile NHS investigations: Update on the themes and lessons learnt from NHS investigations**	

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			this recommendation to consider what more can be done to support employers to understand their legal duties.	**into matters relating to Jimmy Savile'** Published November 2015	
Improving patient safety	**R9**	All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary. (February 2015)	**Government response: accepted in principle. (November 2015)** 42% of Trusts said they had an internet usage policy in place, a further 38% said they would implement any necessary changes (generally adapting existing arrangements) by September with the remainder addressing this later. While trusts have controls over internet access via their own networks many trusts highlighted the difficulty of electronically policing internet access via personal networks. In these instances, trusts will rely on clearly worded policies for patients, visitors and staff/volunteers to highlight what is unacceptable in order to safeguard patients and other visitors. The Information Governance Alliance published draft guidance for trusts on the use of mobile devices in hospitals for consultation which ended in July. The final guidance was published in October 2015.	**Government response document, 'Jimmy Savile NHS investigations: Update on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'** Published November 2015 The October 2015 guidance on mobile phone usage is no longer available online, but an updated policy was published on 13 November 2023	

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Improving patient safety	**R10**	All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers. (February 2015)	**Government response: accepted in principle. (November 2015)** 56% of NHS trusts & foundation trusts identified that they had arrangements and processes in place for the recruitment, checking and general employment of contract and agency staff. A further 30% expect to be compliant by end September 2015. The remaining trusts are in the process of implementing the recommendations through either reviews of their processes or formal internal audit of recruitment and employment practices.	**Government response document, 'Jimmy Savile NHS investigations: Update on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'** Published November 2015	
Improving patient safety	**R11**	NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director. (February 2015)	**Government response: accepted in principle. (November 2015)** 68% of NHS trusts & foundation trusts indicated that they were compliant with this recommendation. A further 23% already had action plans, including timescales for implementation, in place, with plans for compliance by September 2015. The remaining organisations are in the process of implementing the recommendations through either reviews of their processes or formal internal audit of recruitment and employment practices.	**Government response document, 'Jimmy Savile NHS investigations: Update on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'** Published November 2015	

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Improving patient safety	**R12**	NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks. (February 2015)	**Government response: accepted in principle. (November 2015)** 38% of trusts confirmed that they considered their charitable policies robust enough to protect their brand/reputation in all circumstances. Of the remainder, an additional 42% indicated that they would use the recommendation to conduct reviews and identify the necessary actions with specific reference to the management of the Trust's brand and reputation and association with any future major donors and celebrities by end September 2015. 11% committed to achieving this later as part of broader charity governance work. The majority will have completed these reviews by the end of 2015. A small number of trusts (3%) indicated that their charitable connections are small and/or they do not have any dealings with celebrities or donors. Consequently, while they consider that this recommendation is not relevant at the moment, they will assess these risks should the need arise.	**Government response document, 'Jimmy Savile NHS investigations: Update on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'** Published November 2015	
Improving patient safety	**R13**	Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS hospital trusts, (and where applicable, independent hospital and care organisations), comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11. (February 2015)	**Government response: accepted in principle. (November 2015)** Monitor, the Trust Development Authority, the Care Quality Commission and NHS England published a joint statement setting out their response to the Savile investigations and Kate Lampard's Lessons Learnt report in February 2015.	**Government response document, 'Jimmy Savile NHS investigations: Update on the themes and**	

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			The refresh of the NHS England Accountability and Assurance Framework for safeguarding vulnerable people put in place the structure to ensure hospital trusts are compliant with the recommendations. NHS England has established Quality Surveillance Groups on a regional and subregional level. These Quality Surveillance Groups are the appropriate groups to monitor the recommendations following the Savile investigations as they have local commissioners and regulators as members and are able to assess risk and quality issues across the area, using intelligence from a variety of sources. NHS England will advise Quality Surveillance Groups to familiarise themselves with these recommendations, and to request that Clinical Commissioning Groups, Monitor, the Trust Development Authority, and the Care Quality Commission consider the recommendations when undertaking commissioning or regulatory visits in the provider Trusts within the Quality Surveillance Group's area.	**lessons learnt from NHS investigations into matters relating to Jimmy Savile'** Published November 2015	
Improving patient safety	**R14**	Monitor and the Trust Development Authority should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12. (February 2015)	**Government response: accepted in principle. (November 2015)** Monitor and the Trust Development Authority wrote to all NHS trusts and NHS foundation trusts in March to ask them to review their current practice against the recommendations and to develop an action plan in response. Trusts were asked to report back on their proposed actions within three months.	**Government response document, 'Jimmy Savile NHS investigations: Update on the themes and lessons learnt from NHS**	

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			All trusts have responded and set out the action they are taking in response to the recommendations. Monitor and the Trust Development Authority will consider how best to subsume the appropriate recommendations into the oversight framework for NHS trusts and NHS foundation trusts. In July 2015, the Secretary of State for Health also announced a new body formed by Monitor and the Trust Development Authority: NHS Improvement. NHS Improvement holds new safety functions, including a new Independent Patient Safety Investigation Service.	**investigations into matters relating to Jimmy Savile'** Published November 2015	

19 FREEDOM TO SPEAK UP REVIEW

19.1 Introduction

This was an independent, non-statutory review commissioned by the Secretary of State for Health in 2013, into the treatment of NHS staff who raise concerns about safety and other matters of public interest and the handling of those concerns ("**the Review**"). the scope of this Review extended all organisations and individuals who provide NHS services in England. The Review was chaired by Sir Robert Francis KC, and the report was delivered in February 2015. The report can be viewed online.

From the evidence we drew five overarching themes. These are the need for:

1. culture change,
2. improved handling of cases,
3. measures to support good practice,
4. particular measures for vulnerable groups, and
5. extending the legal protection.

All organisations which provide NHS healthcare and regulators should implement the principles and actions set out below, in line with the good practice described in this report.

The twenty principles and associated actions are grouped into five themes:

- Culture change;
- Improved handling of cases;
- Measures to support good practice;
- Particular measures for vulnerable groups; and
- Extending the legal protection

The Review made two recommendations:

1. All organisations which provide NHS healthcare and regulators should **implement the Principles and Actions set out** and in line with the good practice described.

2. The Secretary of State for Health should review at least annually the progress made in the implementation of these Principles and Actions and the performance of the NHS in handling concerns and the treatment of those who raise them, and report to Parliament.

20 principles were set out. Each was supplemented by a list of actions to be undertaken and descriptions of good practice. The Report contains a list of actions showing the organisations responsible for implementing each one. Each of these have been reviewed below.

19.2 Freedom to Speak Up Review: Table of Recommendations

Freedom to Speak Up Review						
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**	**DHSC Comments**
Culture Change						
Improving the ability to raise complaints and concerns	**P1**	**Culture of safety:** Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns. Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis. Action 1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led. *(February 2015)*	Action 1.1: All organisations including providers are responsible for implementing. **NHS Guidance** NHS Improvement and the National Guardian's Office published a guide to the boards and senior leaders on good practice for speaking up in May 2018. **NHS England resource for Senior Leaders (23 June 2022):** Guide and tool for senior leaders to promote a "speaking up" culture in their NHS organisations. *"Guidance to help senior leaders in NHS organisations develop a culture where: leaders and managers encourage workers to speak up, and where matters raised by workers drive learning and improvement."*	NHS improvement and National Guardian Office 'Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts' (May 2018) NHS England, 'The guide for the NHS on freedom to speak up' (NHS		NHSE have published a national Freedom to speak up policy for the NHS, applicable to primary care, secondary care and integrated care systems, focusing on the importance of inclusive and consistent speaking up arrangements and driving learning through listening. With the National Guardian's Office NHSE have also published

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			Action 1.2: System regulators (i.e. Monitor, Care Quality Commission, NHS Trust Development Authority) are responsible for implementing. **Department of Health,** *"To reinforce all of this, the Care Quality Commission inspection process now considers complaints as part of every inspection in primary, secondary and social care and takes a sample of complaints to look at how they have been handled in practice. The local scrutiny function performed by local health watch is also very important as a means to ensuring the local NHS is handling complaints well*." (p. 44)	England, 23 June 2022) Department of Health, Learning not Blaming, (White Paper, Cm 9113, July 2015)		Freedom to speak up (FTSU) guidance and a Freedom to speak up reflection and planning tool, each to help ensure staff have a voice that counts to develop a speaking up culture. NHS England » Freedom to Speak Up national policy, guidance and planning tool CQC's well-led framework incorporates review of FTSU arrangements and culture. Freedom to speak up - Care Quality

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						Commission (cqc.org.uk)
Improving the ability to raise complaints and concerns	**P2**	Culture of raising concerns: Raising concerns should be part of the normal routine business of any well led NHS organisation. Action 2.1: Every NHS organisation should have an integrated policy and a common procedure for employees to formally report incidents or raise concerns. In formulating that policy and procedure organisations should have regard to the descriptions of good practice in this report. Action 2.2: NHS England, NHS Trust Development Authority and Monitor should produce a standard integrated policy and procedure for reporting incidents and raising concerns to support Action 2.1. *(February 2015)*	Action 2.1: All organisations including providers are responsible for implementing. Evidence of NHS England implementation and government position. Achieved through implementation of national freedom to speak up policy which sets minimum standards for local freedom to speak up policies, and NHS England external speaking up policy below in 2.2. (23 June 2022) Action 2.2: NHS England and system regulators (i.e. Monitor, Care Quality Commission, NHS Trust Development Authority) are responsible for implementing. In November 2015 – Monitor, NHS Trust Development Authority (NHS Improvement together at the time) and NHS England ran a consultation on a national whistleblowing policy for the NHS in England. It set out the draft policy created and the consultation questions to finalise it. In April 2016 they took account of the consultation responses and published the final policy. The most up to date policy is on the NHS England website which replaced the previous NHS	**Consultation Page:** Monitor, NHS Trust Development Authority, and NHS England, 'Freedom to speak up: whistleblowing policy for the NHS' (Gov.uk, Last updated 1 April 2016) **National Speaking Up Policy:** NHS England, 'The national speak up policy' (NHS England, latest update		

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			Improvement and NHS England freedom to speak up policies for NHS workers. It applies to all NHS workers.	19 November 2022) **The most up to date external policy by NHS England:** NHS England, 'External freedom to speak up policy for NHS workers' NHS England, last updated 20 June 2023		
Improving the ability to raise complaints and concerns	**P3**	**Culture free from bullying**: Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours. Action 3.1: Bullying of staff should consistently be considered, and be shown to be, unacceptable. All NHS organisations should be proactive in detecting	Action 3.1: All organisations including providers are responsible for implementing. **Department of Health: "***In February 2015, the Secretary of State for Health wrote to the Chairs of NHS Trusts seeking their support to work with the Government to eradicate bullying, intimidation and victimisation. The Government have already taken a*	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015)		The forthcoming Leadership Competency Framework will include key competencies including the highest standards

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		and changing behaviours which amount, collectively or individually, to bullying or any form of deterrence against reporting incidents and raising concerns; and should have regard to the descriptions of good practice in this report. Action 3.2: Regulators should consider evidence on the prevalence of bullying in an organisation as a factor in determining whether it is well-led. Action 3.3: Any evidence that bullying has been condoned or covered up should be taken into consideration when assessing whether someone is a fit and proper person to hold a post at director level in an NHS organisation. *(February 2015)*	*number of steps to protect NHS staff and fully supports the right of staff, working in the NHS to raise concerns and expect all NHS organisations to support staff that wish to do so." (p. 51)* Action 3.2: System regulators (i.e. Monitor, Care Quality Commission, NHS Trust Development Authority) are responsible for implementing. Marked as a criterion on the Care Quality Commission assessment framework under whether an organisation is well-led, though unable to find when bullying was added to the criteria. Action 3.3: All organisations including providers, and system regulators (i.e. Monitor, Care Quality Commission, NHS Trust Development Authority) are responsible for implementing. Mentioned in the Fit and Proper Persons Framework. *(27 September 2023)*	Care Quality Commission, 'Key lines of enquiry, prompts and ratings' NHS England, 'NHS England Fit and Proper Person Test Framework for board members' (27 September, 2023)		of behaviour and not tolerating any form of bullying or harassment.
Regulation and oversight of NHS managers						
Improving NHS culture and governance						The FTSU Guide underlines the importance of leadership behaviours to establishing a speaking up culture. NHS-freedom-to-speak-up-guide-eBook.pdf (england.nhs.uk)

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Improving the ability to raise complaints and concerns	**P4**	**Culture of visible leadership:** All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff. Action 4.1: Employers should ensure and be able to demonstrate that staff have open access to senior leaders in order to raise concerns, informally and formally. *(February 2015)*	NHS takes a national position on the NHS England website but discretion of implementation largely delegated to local Trusts. Action 4.1: All organisations including providers are responsible for implementing. **1. NHS England Website page for Senior Leaders:** Guide and tool for senior leaders to promote a "speaking up" culture in their NHS organisations.*".* *"Guidance to help senior leaders in NHS organisations develop a culture where: leaders and managers encourage workers to speak up, and where matters raised by workers drive learning and improvement."* According to the reflection and planning tool, a senior lead for Freedom to Speak Up should "take responsibility … a*t least every 2 years to complete this reflection tool."* *(23 June 2022)* **2. NHS England Website page for Integrated Care Boards:** *What integrated care boards should do* *"As you agree on ICS-level outcomes for all organisations in your ICS, it's important to think about*	NHS England, 'The guide for the NHS on freedom to speak up' (NHS England, 23 June 2022) NHS England, 'Integrated care boards, integrated care systems and Freedom to Speak Up' (NHS England, 23 June 2022) **National Speaking Up Policy:** NHS England, 'The national speak up policy' (NHS		National FTSU policy since 2016 provided options for staff to speak up, including to an executive and a non-executive FTSU lead.

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			how Freedom to Speak Up will support the delivery of those outcomes in terms of worker voice, worker experience and patient safety. ICBs have a great opportunity to ensure speaking up routes are available for all workers in NHS healthcare providers across the ICS. This must include access to a Freedom to Speak Up guardian(s) at organisation, place and/or system level. Appointing an executive and non-executive lead for Freedom to Speak Up within your ICB will provide leadership for that work." **3. NHS England National Speaking Up Policy** Managers and senior leaders must do online training on Freedom to Speak Up. *"The online module on listening up is specifically for managers to complete and the module on following up is for senior leaders to complete." (P. 3)*	England, latest update 19 November 2022)		
Improving the ability to raise complaints and concerns	**P5**	**Culture of valuing staff**: Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified. Action 5.1: Boards should consider and implement ways in which the raising of concerns can be publicly celebrated. *(February 2015)*	Action 5.1: All organisations including providers are responsible for implementing. Unable to find government or NHS-wide statement on this action. Possibly left to discretion of local Trusts, integrated care board. *(18 November 2022)*			The FTSU Guide requires an annual report to public board from FTSU Guardian re themes and learning from FTSU cases.

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Improving NHS culture and governance	**P6**	**Culture of reflective practice**: There should be opportunities for all staff to engage in regular reflection of concerns in their work. Action 6.1: All NHS organisations should provide the resources, support and facilities to enable staff to engage in reflective practice with their colleagues and their teams. *(February 2015)*	Unable to find government or NHS-wide statement on this action. Possibly left to discretion of local Trusts, integrated care board. Action 6.1: All organisations including providers are responsible for implementing.			NHS England and the NGO have developed a self-reflection and planning tool to be used by Boards in conjunction with freedom to speak up guidance for NHS leaders to help senior leaders identify strengths in themselves, their leadership team and their organisation, and any gaps that need to be addressed.
Better Handling of Cases						
Improving the ability to raise complaints and concerns	**P7**	**Raising and reporting concerns:** All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.	Action 7.1 **and** 7.2: All organisations including providers are responsible for implementing. NHS England has asked NHS Trusts on its website to adopt the Freedom to Speak Up policy and provide assurance to Boards by January 2024.	NHS England, 'Integrated care boards, integrated care systems and		

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		Action 7.1: Staff should be encouraged to raise concerns informally and work together with colleagues to find solutions. Action 7.2: All NHS organisations should have a clear process for recording all formal reports of incidents and concerns, and for sharing that record with the person who reported the matter, in line with the good practice in this report. *(February 2015)*	**NHS England Webpage page for Integrated Care Boards:** *What integrated care boards should do* *"As you agree on ICS-level outcomes for all organisations in your ICS, it's important to think about how Freedom to Speak Up will support the delivery of those outcomes in terms of worker voice, worker experience and patient safety. ICBs have a great opportunity to ensure speaking up routes are available for all workers in NHS healthcare providers across the ICS. This must include access to a Freedom to Speak Up guardian(s) at organisation, place and/or system level. Appointing an executive and non-executive lead for Freedom to Speak Up within your ICB will provide leadership for that work."* Egg *"ICBs must ensure their own ICB staff have access to routes for speaking up including Freedom to Speak Up guardian(s), and associated arrangements by 30 January 2024.* *NHS England has asked that all NHS trusts adopt the policy and apply the guide and improvement tool over the next 18 months and have provided assurance to their public boards by the end of January 2024.*	Freedom to Speak Up' (NHS England, 23 June 2022)		
Improving NHS culture and governance	**P8**	**Investigations**: When a formal concern has been raised, there should be prompt, swift, proportionate,	Action 8.1: All organisations including providers are responsible for implementing.	NHS England, 'The national speak up		

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		fair and blame-free investigations to establish the facts. Action 8.1: All NHS organisations should devise and implement systems which enable such investigations to be undertaken, where appropriate by external investigators, and have regard to the good practice suggested in this report. *(February 2015)*	**NHS England Website:** Achieved through implementation of national freedom to speak up policy which sets minimum standards for local freedom to speak up policies for NHS workers. Page 8 discusses investigation process. *(23 June 2022)*	policy' (NHS England, latest updated 19 November 2022)		
Improving the ability to raise complaints and concerns	**P9**	**Mediation and dispute resolution**: Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns. Action 9.1: All NHS organisations should have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to: • address unresolved disputes between staff or between staff and management as a result of or associated with a report raising a concern, and • repair trust and build constructive relationships. *(February 2015)*	Action 9.1: All organisations including providers are responsible for implementing. **NHS England Website:** The national freedom to speak up policy mentions mediation and facilitated conversations for resolution but is not prescriptive on how it pertains to implement the recommended actions. *(23 June 2022)*	NHS England, 'The national speak up policy' (NHS England, latest update 19 November 2022)		National FTSU policy references health and wellbeing resources available to NHS staff and allows for organisations to add their own local support options.

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Measures to Support Good Practice						
Improving the ability to raise complaints and concerns	**P10**	**Training**: Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them. Action 10.1: Every NHS organisation should provide training which complies with national standards, based on a curriculum devised jointly by Health Education England and NHS England in consultation with stakeholders. This should be in accordance with the good practice set out in this report. *(February 2015)*	Action 10.1: NHS England, Health Education England, and all organisations including providers are responsible for implementing. Jeremy Hunt MP, Secretary of State for Health, oral statement to Parliament: *"Going forward we will ensure that every member of staff, every NHS manager and every NHS leader has proper training on how to raise concerns and how to treat people who raise concerns."* *(11 February 2015)* Department of Health: *"Recommendations will also be made by Health Education England in the autumn on ways in which education and training can be used to improve patient safety."* *(July 2015)* **NHS England Website:** The national freedom to speak up policy asks all workers to complete online training on speaking up. (P. 3)	**Oral statement to Parliament** Jeremy Hunt, Francis Report: 'update and response' (11 February 2015) Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015) NHS England, 'The national speak up		

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			(23 June 2022)	policy' (NHS England, latest update 19 November 2022)		
Improving the ability to raise complaints and concerns	**P11**	**Support**: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling. Action 11.1: The Boards of all NHS organisations should ensure that their procedures for raising concerns offer a variety of personnel, internal and external, to support staff who raise concerns including: a) a person (a 'Freedom to Speak Up Guardian') appointed by the organisation's chief executive to act in a genuinely independent capacity b) a nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports on concerns raised by staff and the organisation's culture to the Board c) at least one nominated executive director to receive and handle concerns d) at least one nominated manager in each department to receive reports of concerns	Action 11.1 **and** 11.2: All organisations including providers are responsible for implementing. **NHS England Website:** Webpage on support scheme after speaking up process. Formerly known as the Whistleblowers Support Scheme, it was created in 2019 as a response to the recommendations from the 2015 Freedom to speak up review. It has been revised based on learning from the previous iterations of the support scheme. Action 11.3: NHS England, and system regulators (i.e. Monitor, Care Quality Commission, NHS Trust Development Authority) are responsible for implementing. **Jeremy Hunt MP, Secretary of State for Health, oral statement to Parliament***: "Freedom to Speak Up Guardians' will report directly to Trust Chief Executives on progress in stamping out the culture of bullying and intimidation that Sir Robert today says is still too common."*	NHS England, 'Speaking Up support scheme' (NHS England) Jeremy Hunt, Francis Report: 'update and response' (11 February 2015) Department of Health, Learning not Blaming, (White Paper, Cm		FTSU Guidance for Boards since 2018 emphasised this further. A Network of Freedom to Speak Up Guardians is in place covering every trust that workers can approach with concerns. Guardians receive training and support from NGO. DHSC has also put in place 'Speak Up Direct' - a helpline and website to support people who want to

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		e) a nominated independent external organisation (such as the Whistleblowing Helpline) whom staff can approach for advice and support. Action 11.2: All NHS organisations should have access to resources to deploy counselling and other means of addressing stress and reducing the risk of resulting illness after staff have raised a concern. Action 11.3: NHS England, NHS Trust Development Authority and Monitor should issue joint guidance setting out the support required for staff who have raised a concern and others involved. *(February 2015)*	*(11 February 2015)* **Department of Health:** *"In addition, we support a free helpline, run by Mencap. The helpline provides independent and confidential advice to staff in the NHS and social care wanting to raise a concern but unsure how to do so or what protections they have in law if they do so. The Whistleblowing Helpline also gives employers advice on best practice in implementing whistleblowing policies that are compliant with the Employment Rights Act 1996. In March 2014, refreshed NHS and Social Care Whistleblowing Guidance was published, aimed at staff and employers". (p. 50)* *(July 2015)* **National speaking up policy:** The national policy directs workers to their local staff intranet and wellbeing support on NHS England. Also highlights organisations such as Speak up Direct, Protect, Trades Union Congress, and ACAS. *(23 June 2022)* **Current NHS England external speaking up policy webpage:** *"You can find out about the local support available to you either on your staff intranet, staff handbook, from your line manager, the practice manager, occupational health department or HR (human*	9113, 2015) <link> NHS England, 'The national speak up policy' (NHS England, latest updated 18 November 2022) NHS England, 'External freedom to speak up policy for NHS workers' NHS England, last updated 20 June 2023		speak up about something and need help on what to do. Page 7 of the National FTSU policy references the health and wellbeing support available to staff who speak up. The national policy allows for organisations to add their own local support options. Speak Up Direct is available to all health and social care staff who want independent help and support about how to speak up about something. Free, independent, confidential

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			resources) team. Where you have them, staff networks can also be a valuable source of support. *You can also access a range of health and wellbeing support via NHS England:* • *Support available for our NHS people* • *Looking after you: confidential coaching and support for the primary care workforce* *NHS England also has a Speaking Up support scheme that you can apply to if you have encountered disadvantage for speaking up."* *(23 June 2022)*			advice on the speaking up process - Speak Up
Improving the ability to raise complaints and concerns	**P12**	**Support to find alternative employment in the NHS**: Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support. Action 12.1: NHS England, the NHS Trust Development Authority and Monitor should jointly devise and establish a support scheme for NHS workers and former NHS workers whose performance is sound who can demonstrate that they are having difficulty finding employment in the NHS as a result of having made protected disclosures.	Action 12.1: NHS England, and system regulators (i.e. Monitor, Care Quality Commission, NHS Trust Development Authority) are responsible for implementing. **Jeremy Hunt MP, Secretary of State for Health, oral statement to Parliament**: *"We will also provide practical help through Monitor, the Trust Development Authority and NHS England to help whistleblowers find alternative employment. The three bodies have agreed a compact for action on this issue and will publish the detailed arrangements later this year."* *"NHS England, Monitor and the NHS Trust Development Authority to devise and establish a*	Jeremy Hunt, Francis Report: 'update and response' (11 February 2015) Department of Health, Learning not Blaming, (White		The Speaking Up Support Scheme has been operating since 2017, but is now focused on supporting workers to move forward following a speaking up process.

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		Action 12.2: All NHS organisations should actively support a scheme to help current and former NHS workers whose performance is sound to find alternative employment in the NHS. *(February 2015)*	*support scheme for NHS workers and former NHS workers, whose performance is sound and who can demonstrate that they are having difficulty finding employment in the NHS as a result of having made protected disclosures;" (p. 22)* *(11 February 2015)* Action 12.2: All organisations including providers are responsible for implementing. **NHS England Webpage on Support:** *"The scheme, formerly known as the Whistleblowers Support Scheme, was created in 2019 as a response to the recommendations from the 2015 Freedom to speak up review."* Webpage on support scheme after speaking up process. Mentions access to wellbeing experts, but no explicit reference to arranging alternative employment.	Paper, Cm 9113, 2015) NHS England, 'Speaking Up support scheme' (NHS England)		
Improving the ability to raise complaints and concerns	**P13**	**Transparency:** All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements**.** Action 13.1: All NHS organisations that are obliged to publish Quality Accounts or equivalent should include in them quantitative and qualitative data describing the number of formally reported concerns in addition	Action 13.1: All organisations including providers are responsible for implementing. Action 13.2: NHS England, system regulators (i.e. Monitor, Care Quality Commission, NHS Trust Development Authority), and all organisations including providers are responsible for implementing.	Prescribed Persons (Reports on Disclosures of Information) Regulations 2017, SI		

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		to incident reports, the action taken in respect of them and feedback on the outcome. Action 13.2: All NHS organisations should be required to report to the National Learning and Reporting System , or to the Independent National Officer described in Principle 15, their relevant regulators and their commissioners any formally reported concerns/public interest disclosures or incidences of disputed outcomes to investigations. National Learning and Reporting System or the Independent National Officer should publish regular reports on the performance of organisations with regard to the raising of and acting on public interest concerns; draw out themes that emerge from the reports; and identify good practice. Action 13.3: a) CEOs should personally review all settlement agreements made in an employment context that contain confidentiality clauses to satisfy themselves that such clauses are genuinely in the public interest. b) All such settlement agreements should be available for inspection by the Care Quality Commission as part of their assessment of whether an organisation is well-led. c) If confidentiality clauses are to be included in such settlement agreements for which Treasury approval is required, the trust should be required to demonstrate	**New Law on Disclosures** On 1 April 2017 a new legal duty came into force which required all prescribed bodies to publish an annual report on the whistleblowing disclosures made to them by workers. Many NHS organisations amount to a" prescribed person" e.g. NHS England, General Medical Council, Nursing and Midwifery Council etc. **National Guardian Speaking Up Data via webpage:** *"Freedom to Speak Up Guardians collect and report anonymised data on the cases raised with them by workers. They have handled over 100,000 cases since the National Guardian's Office first started collecting data in 2017."* *(2017)* Action 13.3: System regulators (i.e. Monitor, Care Quality Commission, NHS Trust Development Authority) and all organisations including providers are responsible for implementing. **National Guardian Settlement Agreement Factsheet via webpage:** National Guardian worked in partnership with other organisations and has factsheet designed to help employers and workers understand their rights when entering into a settlement agreement. It has been produced by NHS Employers in partnership with the National Guardian's Office, following consultation with	2017/ 507, reg 3 List of prescribed people: Guidance National Guardian's Office, 'Speaking Up Resources' (National Guardian) National Guardian's Office, 'Speaking up data' (National Guardian) NHS Employers, 'Settlement agreements – guidance		

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		as part of the approval process that such clauses are in the public interest in that particular case. d) NHS Trust Development Authority and Monitor should consider whether their role of reviewing such agreements should be delegated to the Independent National Officer recommended under Principle 15. *(February 2015)*	UNISON and with six other law firms that provide legal services to the NHS. Factsheet says: *"Settlement agreements must not prevent workers from speaking up, either before or after they have been signed. Workers can and should be supported by employers to speak up, through the appropriate channels, about any matter that may prevent their organisation from delivering high quality safe care."* *(18 February 2019)*	for employers' (18 February 2019)		

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Improving the ability to raise complaints and concerns	**P14**	**Accountability**: Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for: • poor practice in relation to encouraging the raising of concerns and responding to them • the victimisation of workers for making public interest disclosures • raising false concerns in bad faith or for personal benefit • acting with disrespect or other unreasonable behaviour when raising or responding to concerns • inappropriate use of confidentiality clauses Action 14.1: Employers should ensure that staff who are responsible for, participate in, or permit such conduct are liable to appropriate and proportionate disciplinary processes. Action 14.2: Trust Boards, Care Quality Commission, Monitor and the NHS Trust	Action 14.1: All organisations including providers are responsible for implementing. Unable to find government or NHS-wide statement on this action. Possibly left to discretion of local Trusts, Integrated Care Board. Action 14.2 **and** 14.3: System regulators (i.e. Monitor, Care Quality Commission, NHS Trust Development Authority) and all organisations including providers are responsible for implementing. The Care Quality Commission incorporates this as part of their inspection of a service provider being "well-led", though unable to determine when this was included.	Care Quality Commission, 'Key lines of enquiry, prompts and ratings'		The Fit and Proper Persons Framework and accompanying guidance was published to ensure this as part of assessment and referencing on appointment, and review of this on an annual basis, including competence. The forthcoming Leadership Competency Framework will include key competencies in supporting whistleblowers and staff to speak up.

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Regulation and oversight of NHS managers		Development Authority should have regard to any evidence of responsibility for, participation in or permitting such conduct in any assessment of whether a person is a fit and proper person to hold an appointment as a director or equivalent in accordance with the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 regulation 5. Action 14.3: All organisations associated with the provision, oversight or regulation of healthcare services should have regard to any evidence of poor conduct in relation to staff who have raised concerns when deciding whether it is appropriate to employ any person to a senior management or leadership position and whether the organisation is well-led. *(February 2015)*				
Improving the ability to raise complaints and concerns	**P15**	**External Review:** There should be an Independent National Officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report, namely: • review the handling of concerns raised by NHS workers and/or the treatment of the person or people who spoke up, where there is cause for	Action 15.1: NHS England and system regulators (i.e. Monitor, Care Quality Commission, NHS Trust Development Authority), are responsible for implementing. Jeremy Hunt MP, Secretary of State for Health, oral statement to Parliament*: "We will also consult on establishing a new independent National Whistleblowing Guardian as a full time post within*	Jeremy Hunt, Francis Report: 'update and response' (11 February 2015)		

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		believing that this has not been in accordance with good practice • advise NHS organisations to take appropriate action where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect • act as a support for Freedom to Speak Up Guardians • provide national leadership on issues relating to raising concerns by NHS workers • offer guidance on good practice about handling concerns • publish reports on the activities of this office. Action 15.1: Care Quality Commission, Monitor, NHS Trust Development Authority, and NHS England should consider and consult on how such a post might jointly be created and resourced and submit proposals to the Secretary of State, as to how it might carry out these functions in respect of ongoing and future concerns. *(February 2015)*	*the Care Quality Commission to review processes followed in the most serious cases where concerns have been raised about the treatment of whistleblowers."* *(11 February 2015)* Department of Health: *"The Independent National Officer should be appointed by the Care Quality Commission by December 2015. Once in place the Independent National Officer will produce guidance on local implementation of the Freedom to Speak Up Guardian role and how this role will develop; some Trusts have already taken this role forward and have a guardian in place. We expect the Independent National Officer to take account of the good practice already taking place in many Trusts before publishing this guidance;" (p. 21)* *"We now expect local NHS organisations to take forward the actions that are for them in an effective, proportionate and affordable manner and that guidance will be published in due course by the Independent National Officer and the national regulators, as described in the Freedom to Speak Up report." (p. 22)* *"important that there is guidance on what skills will be needed and the type of training that individuals undertaking the Freedom to Speak Up Guardian role*			

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			might require. HEE will develop and publish guidance on training for this role working with the Care Quality Commission and the Independent National Officer. We would expect HEE to take into account the work the INO will undertake around recruitment for this role" (p. 29) *"We have concluded that the role will sit within the Care Quality Commission. We would expect the Care Quality Commission to consult on how the role of the Independent National Officer will be implemented during summer 2015, given the urgent need to establish this position, and would expect the Independent National Officer to be appointed by the end of 2015." (p. 34)*			
Improving the ability to raise complaints and concerns	**P16**	**Coordinated Regulatory Action**: There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns. Action 16.1: Care Quality Commission, Monitor, NHS Trust Development Authority in consultation with the Department of Health should work together to agree procedures and define the roles to be played by each in protecting workers who raise concerns in relation to regulated activity. Where necessary they should seek amendment of the regulations to enable this to happen.	Action 16.1: The Department of Health and system regulators (i.e., Monitor, Care Quality Commission, NHS Trust Development Authority) are responsible for implementing. Unable to find Department of Health's roles for clear delineations of the roles NHS bodies and regulators act in protecting workers. Previous system regulators such as the NHS Trust Development Authority, and Monitor which the Report pertained do no longer exist. However, NHS England has made clear it has powers to oversee investigations or make enquiries if disclosures are made on its website. Action 16.2: Professional regulators (i.e., General Medical Council, Nursing and Midwifery Council,	GMC, 'Speaking Up' (*Page last reviewed: 31 Oct 2022*) NMC, 'NMC welcomes Robert Francis's review into NHS whistleblowing' (11		NGO chair a regular 'Partnership Working Group' forum to ensure coordination and join up of activity across the various organisations involved in speaking up. NHSE have put in place a package of support for

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		Action 16.2: Healthcare professional regulators should review their procedures and processes to ensure compliance with the good practice set out in this report and with this Principle. *(February 2015)*	Professional Standards Authority) are responsible for implementing. Professional regulators largely responded positively to the review and implemented good practice generally in their respective codes and resources. For example: • General Medical Council – collection of resources exploring how to apply our professional standards in practice include a "speaking up hub." • Nursing and Midwifery Council – Following report, introduced revised Nursing and Midwifery Council Code, which is clear about nurses and midwives responsibility to raise any concerns they have about patient safety and act on concerns raised on them. They must not obstruct, intimidate or victimise those who wish to raise concerns.	February 2015)		NHS staff. This includes the wellbeing guardian role to ensure board level scrutiny, and tools and resources to support line managers to hold meaningful conversations with staff to discuss wellbeing. Specialist mental health support is available with one or more mental health hub per region. NHSE have an external FTSU policy that explains how they will handle concerns from workers raised with them.

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						NHS England » The why, what, and how of health and wellbeing guardians
Improving the ability to raise complaints and concerns	**P17**	**Recognition of organisations**: Care Quality Commission should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns. Action 17.1: Care Quality Commission should consider the good practice set out in this report when assessing how organisations handle staff concerns. Good practice should be viewed as a positive factor contributing to a good or outstanding rating as part of their well-led domain. *(February 2015)*	Action 17.1: The Care Quality Commission (a system regulator) is responsible for implementing. The Care Quality Commission's quality statement covers speaking up culture. Quality statements are the commitments that providers, commissioners and system leaders should live up to. The new assessment framework will apply to providers, local authorities and integrated care systems. The Care Quality Commission assesses freedom to speak up under the "Well-led" on. Care Quality Commission says: We expect providers to be aware of and follow the following best practice guidance.	Care Quality Commission, 'Freedom to speak up' (Page last updated: 23 November 2023)		
Particular measures for vulnerable groups						
Improving the ability to raise	**P18**	**Students and Trainees:** All principles in this report should be applied with necessary adaptations to	Action 18.1: Professional regulators (i.e., General Medical Council, Nursing and Midwifery Council,	**National Speaking Up Policy:**		HEE supported trainee and learner awareness of

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complaints and concerns		education and training settings for students and trainees working towards a career in healthcare. Action 18.1: Professional regulators and Royal Colleges in conjunction with Health Education England should ensure that all students and trainees working towards a career in healthcare have access to policies, procedure and support compatible with the principles and good practice in this report. Action 18.2: All training for students and trainees working towards a career in healthcare should include training on raising and handling concerns. *(February 2015)*	Professional Standards Authority) and Health Education England are responsible for implementing. Students explicitly mentioned as having the rights of workers in the national freedom to speak up policy which sets minimum standards for local freedom to speak up policies. Action 18.2: Health Education England is responsible for implementing. In October 2020 Health Education England, in partnership with the National Guardian offered e-learning modules for raising concerns for all staff in healthcare, which includes students. Unable to locate information that training for students and trainees working towards a career in healthcare includes handling concerns within their curricula.	NHS England, 'The national speak up policy' (NHS England, latest update 19 November 2022) **Introduction of new learning modules** HEE, 'Freedom to Speak Up training for all workers' (27 October 2020)		FTSU policies and procedures through learning modules on e-Learning for Health, "Speak up, Listen Up Follow Up" in conjunction with the National Guardian's Office, and further materials produced with clinical fellows to raise learner awareness of process for FTSU. The National Education and Training Survey (NETS) includes questions on learner awareness of how to access support from their local FTSU Guardian and whether they know how to raise

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						concerns locally in their clinical learning environment. Products such as the national Freedom to Speak Up policy and NGO's Freedom to Speak Up Training are all designed to be inclusive of everyone involved in delivering NHS care.
Improving the ability to raise complaints and concerns	**P19**	**Primary Care**: All principles in this report should apply with necessary adaptations in primary care. Action 19.1: NHS England should include in its contractual terms for general/primary medical services standards for empowering and protecting staff to enable them to raise concerns freely, consistent with these Principles. Action 19.2: NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these	Action 19.1: NHS England is responsible for implementing. Unable to find evidence that GP contracts include this provision. NHS England guide states in 2017: *"NHS England will keep the recommendation for introducing contractual requirements to have a*	NHS England, 'Freedom to speak up in Primary Care' (11 November 2017) NHS England, 'Integrated		Referenced in the NHS standard contract, and assurance provided through the electronic practice self-declaration (eDEC) system that GPs have speaking up

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		Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with this report. Action 19.3: In regulating registered primary care services Care Quality Commission should have regard to these Principles and the extent to which services comply with them. *(February 2015)*	*whistleblowing policy in place under review in light of reported progress."* Action 19.2: NHS England and all organisations including providers are responsible for implementing. In 2017 NHS England issued official guidance in response to Inquiry for primary care workers. Guidance states: "*Each NHS primary care provider should review and update their local policies and procedures by September 2017, so that they align with this guidance;"* Current NHS England site information on freedom to speak up clarifies the expectations of integrated care boards (ICBs) and integrated care systems (ICSs) which includes primary care workplaces. Action 19.3: Care Quality Commission is responsible for implementing. The Care Quality Commission assesses freedom to speak up under the "Well-led" criterion, similar to secondary providers. Care Quality Commission says: We expect providers to be aware of and follow the following best practice guidance.	care boards, integrated care systems and Freedom to Speak Up' (NHS England, 23 June 2022) Care Quality Commission, 'Culture of the organisation (healthcare services)' (Page last updated: 11 April 2022)		arrangements in place for their staff. FTSU guidance for primary care was published in 2016, and since superseded in 2022 by the FTSU Guide.
Enhancing the legal protection						

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Improving the ability to raise complaints and concerns	**P20**	**Legal protection should be enhanced** Action 20.1: The Government should, having regard to the material contained in this report, again review the protection afforded to those who make protected disclosures, with a view to including discrimination in recruitment by employers (other than those to whom the disclosure relates) on grounds of having made that disclosure as a breach of either the Employment Rights Act 1996 or the Equality Act 2010. Action 20.2: The list of persons prescribed under the Employment Rights Act 1996 should be extended to include all relevant national oversight, commissioning, scrutiny and training bodies including NHS Protect, NHS England, NHS Clinical Commissioning Groups, Public Health England, Healthwatch England, local Healthwatch, Health Education England, Local Education and Training Boards and the Parliamentary and Health Services Ombudsman. Action 20.3: The Government should ensure that its proposal to widen the scope of the protection under the Employment Rights Act 1996 includes all students working towards a career in healthcare. *(February 2015)*	Action 20.1, 20.2 **and** 20.3: The Department of Health is responsible for implementing. The following are now 'prescribed persons' under the Public Interest Disclosure Act: NHS England, NHS, Public Health England, Healthwatch England, local Healthwatch, Health Education England, Local Education and Training Boards. A few of the organisations recommended to be included are no longer in existence, such as NHS Protect and Clinical Commissioning Groups. Public Health England and the Parliamentary and Health Services Ombudsman are not 'prescribed persons'. **Jeremy Hunt MP, Secretary of State for Health, oral statement to Parliament:** *"Because too often the system has closed ranks against whistleblowers, making it impossible for them to find another job, I can today announce that the Government will legislate to protect whistleblowers who are applying for NHS jobs from discrimination by prospective employers. With Opposition support these necessary regulation making powers could be on the statute book in this Parliament."* **Department of Health:** *"Since the publication of the report, a regulation making power was added to the Small Business, Enterprise and Employment Act*	Public Interest Disclosure (Prescribed Persons) (Amendment) (No. 2) Order 2015/1981, schedule 1 or the DBT's link to the list here (accessed 28/11/23) Jeremy Hunt, Francis Report: 'update and response' (11 February 2015) Department of Health, Learning not Blaming, (White		List of prescribed persons has been widened: Whistleblowing: list of prescribed people and bodies - GOV.UK (www.gov.uk) Extension of whistleblowing protections to student nurses and student midwives who have undertaken work placements: The Protected Disclosures (Extension of Meaning of Worker) Order 2015 (legislation.gov.uk)

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			2015 (the SBEEA) to prohibit discrimination against whistleblowers (or applicants believed by the prospective employer to have been whistleblowers) when they apply for jobs with prescribed NHS employers." *The SBEEA also introduced a regulation making power to impose a duty on prescribed persons (such as the Care Quality Commission, Monitor and the professional regulatory bodies) to report annually on whistleblowing disclosures made to them."* **Department of Health***: "Government have previously extended the definition of "worker" within the whistleblowing statutory framework in the Employment Rights Act 1996 to include student nurses and student midwives; the intention is to extend the definition to all students studying for a career in healthcare when Parliamentary time allows."* *"Freedom to Speak Up Guardian who is also an employee of the whistleblower's employer, they would potentially be making a protected disclosure to their employer under existing legislation. Therefore the whistleblower has a statutory right not be subjected to any detriment by their employer. Therefore, there is no intention to make new legislation or amend existing legislation" (p. 50)* **The National Guardian's Office Website:** NGO *is a 'prescribed person'. Prescribed people and bodies*	Paper, Cm 9113, 2015) National Guardian Office Website, Prescribed Persons Report Small Business, Enterprise and Employment Act 2015		

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			provide workers with an opportunity to make their public interest disclosure to an organisation other than their employer.			

20 MORECAMBE BAY INVESTIGATION

20.1 Introduction

Dr Bill Kirkup CBE, chair of the investigation, published an independent report into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013.

The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH). This Report details a distressing chain of events that began with serious failures of clinical care in the maternity unit at Furness General Hospital, part of what became the University Hospitals of Morecambe Bay NHS Foundation Trust.

The report was delivered in March 2015, and can be viewed online. The report makes 44 recommendations for the Trust and wider NHS, aimed at ensuring the failings are properly recognised and acted upon.

The first section is directed at the University Hospitals of Morecambe Bay NHS Foundation Trust. The Trust has made significant progress recently, but it is essential that this is maintained, and organisational culture is notoriously resistant to change. The second section is directed at the wider NHS, to minimise the chance that these events would be repeated elsewhere.

The Department of Health, in its ‘Learning not blaming’ report, responded to the three inquiries. The findings in the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay Investigation were commented on and the recommendations were broadly addressed.

20.2 Morecambe Bay Investigation: Table of Recommendations

Morecambe Bay Investigation						
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**	**DHSC Comments**
Recommendations for the University Hospitals of Morecambe Bay NHS Foundation Trust						
	1	The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report. (March 2015)	In the Department of Health's report (July 2015), it states that the Trust has: *"Formally admitted the extent and nature of the problems that occurred and apologised individually to families."* (p. 65)	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015)		
Improving patient safety	**2**	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review should be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere. (March 2015)	In the Trust's 'One Year on' report (April 2016): Implemented the Kirkup Education Learning and Development Project. Director of Workforce and Organisational Development responsible. (p. 66-73) The project has led to: • *The agreement of clear and explicit training expectations, split into mandatory and essential role-specific training, for each of the professional staff groups in the women's & children's services [WACS] and in critical care; with clear performance monitoring to ensure*	University Hospitals of Morecambe Bay, "One Year On' How we implemented the Kirkup Report' (April 2016)		

Morecambe Bay Investigation						
Improving patient safety	**3**	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015. (March 2015)	*that active management trajectories were in place to ensure compliance.* • *The development of the training management system (TMS) to support the ongoing monitoring and management of all aspects of mandatory and role specific training on a real-time basis, with all training data captured in a single central resource.* • *Preceptorships and leadership development programmes being implemented within the women's and children's services division.* (p. 66-73)			
Improving NHS culture and governance	**4**	Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015. (March 2015)				
Improving NHS culture and governance	**5**	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms	In the Department of Health's report (July 2015), they state that the Trust has: *"Started to strengthen multi-disciplinary working - in particular between paediatricians, midwives, obstetricians and neonatal staff – as part of a broader, ongoing programme of work"* (p. 65) In the Trust's 'One Year on' report (April 2016):	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015) University Hospitals of		

Morecambe Bay Investigation						
		of employment. These measures should be identified by April 2015 and begun by June 2015. (March 2015)	Implemented the Clinical Quality Project. Executive Nurse Director responsible for overseeing. (p. 86)	Morecambe Bay, "One Year On' How we implemented the Kirkup Report' (April 2016)		
Improving NHS culture and governance	**6**	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015. (March 2015)	In the Trust's 'One Year on' report (April 2016): Implemented the Clinical Quality Project. Executive Nurse Director responsible for overseeing. (p. 86) *"Throughout the project clinical guidance and procedures as well as training and education plans for Women's and Children's Services [WACS] that were already in place have been reviewed, refreshed and where required updated. Opportunities have been taken to improve further on those developments and changes already made prior to Kirkup reporting in March 2015 to ensure high quality safe maternity services that are continuously ensuring women receive the best care for themselves and their babies that meets their wishes and needs. Service user involvement and input into this as well as a wide spectrum of professional groups represented has really enabled this principle to be underpinned in everything the project has undertaken."* (p. 87)	University Hospitals of Morecambe Bay, "One Year On' How we implemented the Kirkup Report' (April 2016)		
Improving NHS culture	**7**	The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of				

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and governance		maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015. (March 2015)	*"there is updated clinical guidance that reflects latest NICE Guidance in respect of antenatal risk assessment, Intrapartum risk assessment, and transfer of mothers to other units that ensures the safe birth of their baby in a unit equipped and skilled to look after their specific care needs. This guidance has been refreshed and since 2012 has been standardised across all three maternity units at MBHT."* (p. 87)			
Improving NHS culture and governance	**8**	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016. (March 2015)	In the Trust's 'One Year on' report (April 2016): Implemented the Kirkup Workforce Project. Chief Operating Officer responsible for overseeing. (p. 78) Outcomes achieved: *"Development of a Trust Recruitment and Retention strategy and an overarching Better Care Together Recruitment and Retention strategy across our partner organisations* *Development of bespoke recruitment plans for medical, nursing/midwifery, and allied health professional staff groups […] Regular review of recruitment activity and progress via the Workforce Assurance Committee Contracts of Employment reviewed to ensure flexibility in location cross-Bay in line with service needs"* (p. 80)	University Hospitals of Morecambe Bay, "One Year On' How we implemented the Kirkup Report' (April 2016)		

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Improving NHS culture and governance	**9**	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015. (March 2015)	In the Trust's 'One Year on' report (April 2016): Project Title: Governance Recommendations (p. 89) and Kirkup Workforce Project (p. 78). 9.1 *"a multidisciplinary approach to the development, ratification and implementation of all procedural documents to ensure consistency of approach across the Bay underpinning the delivery of safe high-quality care by an engaged and knowledgeable workforce."* (p. 91) 9.2 *"Cross Bay Obstetric and Midwifery guidelines in place … Development of Multi-Disciplinary and Speciality specific training and development […] Specialist leadership roles for nursing and midwifery roles – including, for example, the development of governance, educational, quality & safety, risk, bereavement roles."* (p. 81)	University Hospitals of Morecambe Bay, "One Year On' How we implemented the Kirkup Report' (April 2016)		
Improving NHS culture and governance	**10**	The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying' and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable	In the Trust's 'One Year on' report (April 2016): *"Board of UHMBFT made initial approaches to Central Manchester University Hospitals NHS FT, and responded to an approach from Lancashire Teaching Hospitals NHS FT. During these discussions between Chief Executives both organisations expressed interest in becoming Maternity Strategic Partners.*	University Hospitals of Morecambe Bay, "One Year On' How we implemented the Kirkup		

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		partner is forthcoming, this arrangement should be begun by September 2015. (March 2015)	*The parties to Recommendation 10 are therefore:* - *Central Manchester University Hospitals NHS FT [CMFT]* - *Lancashire Teaching Hospitals NHS FT [LTH]* - *NHS Cumbria CCG, and NHS Lancashire North CCG as Associate Partners."* (p. 32)	Report' (April 2016)		
Improving the ability to raise complaints and concerns	**11**	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty In line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy. This should be begun with maternity staff by April 2015 and rolled out to other staff by April 2016. (March 2015)	In the Department of Health's report (July 2015), they state that the Trust has: *"With maternity staff, begun to review how investigations into incidents are carried out and started a programme to raise awareness of incident reporting…"* (p. 65)	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015)		
Improving NHS culture and governance	**12**	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review				

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		should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016. (March 2015)				
Improving the ability to raise complaints and concerns	**13**	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015. (March 2015)	In the Trust's 'One Year On' report (April 2016): Implemented the Governance Recommendations Project. *"Our complaints and PALS procedures align with the ombudsman guidelines and we have developed a high quality response process for complaints. The Patient Relations team to support and facilitate the Divisional teams with any complaints received and provide staff training …Every complainant has an allocated case officer as a point of contact and liaison. The increase in patient customer contact has enabled the identification of all concerns at an early stage reducing dissatisfaction with responses. Regular audit is undertaken to monitor performance …"* (p. 92)	University Hospitals of Morecambe Bay, ''One Year On' How we implemented the Kirkup Report' (April 2016)		
Improving patient safety	**14**	The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has	In the Department of Health's report (July 2015), they state that the Trust has:	Department of Health, Learning not Blaming, (White		

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		implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015. (March 2015)	*"Reviewed clinical leadership in terms of individuals and structures in obstetrics, paediatrics and midwifery"* (p. 65)	Paper, Cm 9113, 2015)		
Improving NHS culture and governance	**15**	The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed. (March 2015)	In the Trust's 'One Year On' report (April 2016): Project implemented: Governance Recommendations. *"The audit process has been standardised and an electronic audit module for the registering, monitoring and reporting of audit has been developed.* *…* *During 2014/15 Internal Audit undertook a programme of audit in relation to Trust Governance processes and the following areas were found to have significant assurance … [etc.]"* (p. 93)	University Hospitals of Morecambe Bay, "One Year On' How we implemented the Kirkup Report' (April 2016)		
Regulation and oversight of NHS managers	**16**	As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate	In the Trust's 'One Year On' report (April 2016): Project: Kirkup Workforce Project. *"Non-Executive Directors chair sub-board assurance meetings including quality, finance and workforce committees.*	University Hospitals of Morecambe Bay, "One Year On' How we implemente		

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		guidance and where necessary training. This should be completed by December 2015. (March 2015)	*Annual Mandatory training for Risk and Incident management training, which includes feedback of incidents (e-learning package).”* (p. 81)	d the Kirkup Report' (April 2016)		
	17	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en-suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017. (March 2015)	In the Trust's 'One Year On' report (April 2016): New build proposed. *“Following sign-off by the UHMBFT Trust Board on 30 March 2016 there will be a series of design team meetings between April and the end of July 2016. These meetings will involve the architects, the preferred provider, the Trust, and a full range of stakeholders as required. Work will commence on site in September 2016 with handover on completion in November 2017.”* (p. 42)	University Hospitals of Morecambe Bay, “One Year On' How we implemented the Kirkup Report' (April 2016)		
	18	All the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.	In the Department of Health's report (July 2015), they state that the Trust has: *“Ensured that in carrying out all of these, the Trust is working closely with the Care Quality Commission, Monitor, NHS England and others.”* (p. 65)	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015)		

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		(March 2015)				
Recommendations for the wider NHS						
Improving patient safety	**19**	In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council. (March 2015)	Department of Health response (July 2015): *"We accept this recommendation. … The General Medical Council and the Nursing and Midwifery Council have emphasised that they have reviewed the findings of the Morecambe Bay Investigation Report and are acting on relevant recommendations … can take appropriate action against anyone who they suspect has broken their professional code"* (p. 66)	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015)		In May 2018, at the request of both DHSC and the NMC, the Professional Standards Authority published a 'Lessons Learned Review' into the handling of concerns relating to the handling of the Morecambe Bay fitness to practise cases. https://www.professionalstandards.org.uk/docs/default-source/publications/nmc-lessons-learned-review-may-2018.pdf
Improving patient safety	**20**	There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the	Department of Health response (July 2015): *"We accept this recommendation. A review of maternity care, which will also consider neonatal*	Department of Health, Learning not Blaming,		Baroness Cumberlege's review's terms of reference included

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		requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of units required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence. (March 2015)	*care and paediatrics in the context of maternity care, is underway."* (p. 67) *"NHS England announced a review of maternity services on 3 March 2015. Baroness Cumberlege is the independent Chair leading the review and is being supported by a core team of experts."* (p. 67)	(White Paper, Cm 9113, 2015) Baroness Cumberledge, 'National Maternity Review'		an expectation that it would pay particular attention to the challenges of more geographically isolated areas, as highlighted in the Morecambe Bay Investigation report. Better Births, the report of the independent maternity review, was published on 23 February 2016. Subsequently, and in response to Better Births, a specific review of neonatal critical care, chaired by Professor Neil Marlow, was undertaken and is now being implemented.

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Improving patient safety	**21**	The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research, yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England. (March 2015)	Department of Health response (July 2015): *"NHS England are establishing Vanguard sites to explore how new models of care can address the challenges faced by services that are rural, geographically isolated or difficult to recruit to.* (p. 68) *[…]* *The NHS Five Year Forward View set out a way forward for the NHS that includes new and different care models … be more community-based.* (p. 68) *[…]* *NHS England, Monitor and the NHS Trust Development Authority have also recently announced the first locations to enter into the Success Regime, in which the tripartite partners will jointly oversee a package of challenge and support for some of the most challenged health economies."* (p. 69)	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015)		Broader work is underway across NHS England to build the realities of rural service delivery into national policy decisions, including bringing rural hospitals into strategic national discussions. Recent initiatives that have the potential to address sustainable service delivery in rural areas include: • Trialling new competency-based workforce approaches and

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						intake models in A&E • Funding pilots into rural medical recruitment via the Medical Education Reform Programme • Accelerating the spread of innovative practice via peer learning networks and (e.g. rural local maternity network) New and expanding telehealth approaches improving access to specialist input. The NHS Long Term Plan included a commitment to "develop a standard model of delivery in smaller acute

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						hospitals who serve rural populations".
Improving NHS culture and governance	**22**	We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives. (March 2015)	Department of Health response (July 2015): *'Health Education England (HEE) … established a Working Group to consider the issues raised by the Investigation in relation to making best use of smaller units in the provision of training. HEE intends to complete its initial review by the spring of 2016.'* (p. 70) Health Education England published the findings of this in Spring 2016: this review recommends that all trusts and learning education providers continue to support clinical education and training. This review makes a number of other recommendations.	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015) Health Education England Report Spring 2016 report		
Improving NHS culture and governance	**23**	Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff. We recommend that this build on national work already begun on how such a	Department of Health response (July 2015): *'We accept this recommendation in principle. A new national, Independent Patient Safety Investigation Service […] that will conduct independent, expert-led investigations into patient safety incidents from 1 April 2016.'* *'On mandatory reporting and standardised reviews of perinatal deaths, the Department is working with NHS England, the Scottish, Welsh and Northern Irish health departments along with the Royal College of Midwives and the Royal College of*	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015) **Independent Patient Safety Investigatio**		In 2020 the Patient Safety Incident Response Framework was published by NHSE. The PSIRF outlines how providers should respond to patient safety and how and when a patient safety investigation should be conducted.

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		process would work. Action: the Care Quality Commission, NHS England, the Department of Health. (March 2015)	*Obstetricians and Gynaecologists and Sands (the leading stillbirth charity) to* *consider how standardised reviews for all perinatal deaths might be introduced."* (p.71) *"In line with this recommendation, the Secretary of State for Health asked Mike Durkin, Director of Patient Safety at NHS England, to develop and publish clear standards and guidelines for incident reporting. Following this, NHS England published a revised Serious Incident Framework in March 2015."* (p.72) **Healthcare Safety Investigation Branch (HSIB)** The Independent Patient Safety Investigation Service is now the Healthcare Safety Investigation Branch which started running in 2016. *"IPSIS Expert Advisory Group was set up to make recommendations on how the new Independent Patient Safety Investigation Service would work. Following feedback from the group and others, the function's name was changed to the Healthcare Safety Investigation Branch (HSIB)."* **Introduction and development of the national Perinatal Mortality Review Tool**	**n Service / HSIB** 'Healthcare Safety Investigation Branch (HSIB) Expert Advisory Group' **PMRT** Perinatal Mortality Review Tool webpage PMRT, 'Learning from Standardised Reviews When Babies Die' First Annual Repot (October 2019)		https://www.england.nhs.uk/wp-content/uploads/2020/08/200312_Introductory_version_of_Patient_Safety_Incident_Response_Framework_FINAL.pdf Safety Action 10 of the CNST Maternity Incentive Scheme for year four asks Trusts to report 100% of qualifying cases to HSIB and the NHS Resolution Early Notification Scheme: https://resolution.nhs.uk/wp-content/uploads/2022/05/MIS-year-4-relaunch-guidance-May-2022-converted.pdf

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			Perinatal Mortality Review Tool (PMRT) was consequently developed and started in February 2017. (p. 1)			
Improving the ability to raise complaints and concerns	**24**	We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England. (March 2015)	Department of Health response (July 2015): **New Duty of Candour** *"A duty of candour has been introduced … All providers must now comply with a new legal requirement for openness – the duty of candour – as a condition of their registration with the Care Quality Commission and hence a condition of their providing care."* (p. 73) **New Serious Incident Framework** *"The new NHS England Serious Incident Framework, published on 27 March 2015, also requires providers to: comply with national requirements and guidance. (p. 73)* ***NHS England Webpage*** *"… in August 2022 …[NHS England] published the new Patient Safety Incident Response Framework (PSIRF), which will replace the current Serious Incident Framework. There will be a 12-month period where organisations prepare for the transition to PSIRF, which we expect to be completed by Autumn 2023."*	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015) NHS England, 'Serious Incident framework'		In 2021, new guidance was published on involving patients in safety which sets out patient involvement in the response to a patient safety incident including any investigation.

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			Professions regulating duty of candour *"Duty of candour … responsibility is set out in their respective professional codes of conduct. Department is pleased to note that the General Medical Council and the Nursing and Midwifery Council launched their new joint guidance … on 29 June 2015."* (p. 74)			
Improving NHS culture and governance	**25**	We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission. (March 2015)	Department of Health response (July 2015): In its response, the Department of Health noted that there are already existing obligations on NHS Trusts within this recommendation: • Disclose to the Care Quality Commission of serious incidents. • Monitor and the Care Quality Commission use their respective statutory information-gathering powers to require NHS Trusts and Foundation Trusts to notify them. • Trusts also have to report in their Quality Account on the number of patient safety incidents. However also mentioned introduction of *"a new national, Independent Patient Safety Investigation Service. The Government intend to bring under the single leadership of Monitor and the NHS Trust Development Authority responsibility for leading the patient safety functions that currently sit with NHS England."* (p. 76)	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015) **Independent Patient Safety Investigation Service / HSIB** 'Healthcare Safety Investigation Branch (HSIB) Expert		

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				Advisory Group'		
Improving the ability to raise complaints and concerns	**26**	We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health. (March 2015)	Links to Freedom to Speak Up Inquiry – see Principle 2 and Principle 20 of the Recommendations. NHS England introduces a clear national policy on Whistleblowing which applies to all NHS providers.	**National Speaking Up Policy:** NHS England, 'The national speak up policy' (NHS England, latest update 19 November 2022)		
Improving patient safety	**27**	Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. Action: the General Medical Council, the Nursing and Midwifery Council, the Professional Standards Authority for Health and Social Care.	Department of Health response (July 2015)*:* *"We accept this recommendation. A review of professional codes is under way … Professor Sir Bruce Keogh has been asked to review the professional codes."* (p. 78) Whilst there is information online which shows that Sir Bruce Keogh sent a letter to the Secretary of State updating on his review, a complete report of	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015) **Letter**		

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		(March 2015)	his assessment of the professional codes could not be found. The Department of Health also mentioned that there is existing guidance for both the General Medical Council and the Nursing and Midwifery Council to require registrants to raise concerns and act where patient safety is at risk.	Professor Sir Bruce Keogh KBE (16 July 2015)		
Regulation and oversight of NHS managers	**28**	Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts. (March 2015)	Department of Health response (July 2015): Recommendations accepted in principle. *"The General Medical Council and the Nursing and Midwifery Council already have guidance on leadership and management." (p. 79)* *The Faculty of Medical Leadership and Management has published the first UK standards of medical leadership. (p. 79)* *Secretary of State asked Professor Sir Bruce Keogh to review the Professional Codes for doctors and nurses. (p. 80)* Whilst there is information online which shows that Sir Bruce Keogh sent a letter to the Secretary of State updating on his review, a complete report of his assessment of the professional codes could not be found.	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015) **Letter** Professor Sir Bruce Keogh KBE (16 July 2015)		
Regulation and oversight of NHS managers	**29**	Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts.				The Faculty of Medical Leadership and Management (FMLM) published the 2nd edition of UK standards of medical leadership

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		(March 2015)	*"As part of the Care Quality Commission's new inspection regime, they ask five key questions of all health and care services … key lines of inquiry include a focus on staff having the right skills and training to perform their role effectively." (p. 80)*			in Oct 2016 and 3rd edition in Dec 2020. The NMC standards for professional competence include standards relating to leadership, management and team working. Within this area there are two main aspects to the standards: all nurses must demonstrate their knowledge and competence in both, in order to register as a nurse. In addition, the NHS Leadership Academy has produced its Healthcare Leadership Model: the nine dimensions of leadership behaviour, which applies to both

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						clinical and non-clinical leaders.
Improving NHS culture and governance	**30**	A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission. (March 2015)	Department of Health response (July 2015): They will give "further thought" to an additional protocol. (p. 81) However, unable to find any follow up to this. *"There is existing legislation in relation to how public bodies and professionals should behave with respect to coronial processes."* (p. 81) *"The new Nursing and Midwifery Council Code requires nurses and midwives to cooperate with all investigations and audits and to be open and candid with service users about all aspects of care and treatment, including when any mistake or harm has taken place."* *"The General Medical Council's publication Good Medical Practice and supporting guidance includes clear requirements for medical doctors to cooperate with formal inquiries, including inquests*" (p. 81)	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015)		
Improving the ability to raise complaints and concerns	**31**	The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere	Department of Health response (July 2015): *"We accept this recommendation in principle and recognise that there are still challenges to overcome …. However, we do not believe that another*	Department of Health, Learning not Blaming, (White		

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		lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman. (March 2015)	*fundamental review will help. The issues are already well documented."* (p. 84) Department of Health outlines the issues in the complaints system and what they are doing in response, such as *"posters on every hospital ward and, through Healthwatch England working with Citizen's Advice, ensured there is accurate information online about how to complain."* (p. 83-4)	Paper, Cm 9113, 2015)		
Improving NHS culture and governance	**32**	The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (Midwifery regulation in the United Kingdom) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the	Department of Health response (July 2015): *We will therefore modernise the regulatory regime for midwifery.* *"Government committed in March to the removal of the Nursing and Midwifery Council's oversight of midwifery supervision, and will work with the UK chief nursing officers to design a new system of supervision that is proportionate and recognises the importance of managing risks and promoting safety*" (p. 86)	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015) **Paper for Consultation** Department of Health, 'The Nursing and		The Nursing and Midwifery (Amendment) Order 2017 separated the function of midwifery supervision, which is the responsibility of the employer, from regulatory activity, which is the responsibility of the Nursing and Midwifery Council. This brought the regulation of

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		system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council. (March 2015)		Midwifery Council - amendments to modernise midwifery regulation and improve the effectiveness and efficiency of fitness to practise processes' (April 2016) **Policy Paper** Department of Health and Social Care, 'Proposals for changing the system of midwifery supervision in the UK'		midwives into line with the arrangements for other regulated professions and means that supervisors are no longer involved in regulatory investigations and sanctions. Subsequently, A-EQUIP, a new, non-statutory model of supervision for midwives was developed and rolled out in each of the four countries of the UK with NHS England leading this work in England. The new model focuses on the professional and developmental aspects of the role.

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				(22 January 2016) **Statutory Order** Nursing and Midwifery (Amendment) Order 2017, SI 2017/321		
Improving NHS culture and governance	**33**	We carefully considered the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. Action: Monitor, the Care Quality Commission, the Department of Health. (March 2015)	Department of Health response (July 2015): Accept this recommendation. *"An updated Memorandum of Understanding between Monitor and the Care Quality Commission was published on 26 February 2015" (p. 87)* *"Both organisations have improved how they work together in areas including: Monitor's assessment process and significant transaction reviews, management of Care Quality Commission registration requirements, management of risk, and joint escalation and enforcement of the new licensing regime."* (p. 88)	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015)		Although Monitor has come together, first with the TDA and then with NHS England, the MoU still stands.

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Improving NHS culture and governance	**34**	The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman. (March 2015)	Department of Health response (July 2015): Accepted. *"A new Memorandum of Understanding between the Care Quality Commission and the Parliamentary and Health Service Ombudsman was signed in September 2013 which outlined how the two organisations will collaborate, co-operate and share information relating to their respective roles."* (p. 88)	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015) **MOU** MOU between Parliamentary Health Service Ombudsman and Care Quality Commission		
Improving NHS culture and governance	**35**	The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the	Department of Health response (July 2015): Accepted in principle. *"through the newly re-established National Quality Board we will continue to improve both the operation of the oversight arrangements in place at present and the understanding of those arrangements by NHS organisations and the public." (p. 89)* *"The Government intend to bring under the single leadership of Monitor and the NHS Trust*	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015)		Quality concerns and risks feed into the wider cross-system quality governance framework as set out by the NQB's framework for System Quality Groups (SQG), updated in January 2022:

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		Care Quality Commission, NHS England, Monitor, the Department of Health. (March 2015)	*Development Authority the responsibility for leading the patient safety functions that currently sit with NHS England."* (p. 89)			https://www.england.nhs.uk/publication/national-guidance-on-system-quality-groups/
Improving NHS culture and governance	**36**	The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health. (March 2015)	Department of Health response (July 2015): Accepted in principle. *"the Foundation Trust application process has now been significantly improved, requiring a strong focus on quality of care as well as on governance and good financial control.* *The Care Quality Commission now works closely with Monitor and the NHS Trust Development Authority to share intelligence about the Trusts' performance capacity and capability.* *The Care Quality Commission's new inspection model, including the development of its intelligent monitoring tool, ensures that issues of concern are picked up earlier and can be addressed."* (p. 91)	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015)		
Improving NHS culture and governance	**37**	Organisational change that alters or transfers responsibilities and accountability carry significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in	Department of Health response (July 2015): Accepted. *"The Department of Health issued guidance to NHS bodies in transition in September 2011 setting out*	Department of Health, Learning not Blaming, (White		The Records Management Code of Practice for Health and Social Care 2016 sets out

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		future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health. (March 2015)	*the effective management of records during organisational change*. *National Archives has oversight of records management within Government departments and publishes guidance on best practice. They have recently revised the guidance on "Machinery of Government Changes" which the Department follows when transferring information assets between owners.* *The National Archives have considered the Department's records management compliance as part of their Information Management Assessment in October 2014, the report of which will be published shortly." (p. 91-92)*	Paper, Cm 9113, 2015) **Mentioned Guidance** Cabinet Office, 'Machinery of Government Guidance' (October 2015) Department of Health, 'Information Management Assessment' (May 2015)		what people working with or in NHS organisations in England need to do to manage records correctly. It is based on current legal requirements and professional best practice and was published on 20 July 2016 by the Information Governance Alliance (IGA). The Department revised and published its Information Management Policy in April 2018.
Improving patient safety	**38**	Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity	Department of Health response (July 2015): Accepted.	Department of Health, Learning not Blaming, (White		A Perinatal Mortality Review Tool was launched in January 2018 and has now been implemented

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		units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England. (March 2015)	*"MBRRACE-UK has established a system to systematically collect and report surveillance information on all stillbirths and neonatal deaths nationally. MBRRACE-UK published its first Perinatal Mortality Surveillance Report on the 10th June 2015 (for 2013). […] Any Care Quality Commission maternity outlier is alerted to Trusts where there is a cause for concern. In addition the Care Quality Commission and MBRRACE are establishing pursuing a data-sharing agreement which would allow inspectors to receive a regular update of all maternal deaths"* (p. 93)	Paper, Cm 9113, 2015) MBRRACE-UK, 'Perinatal Mortality Surveillance Report' (June 2015)		in 100% of English trusts.
Improving patient safety	**39**	There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are	Department of Health response (July 2015): Accepted in principle. *"The medical examiners system has been trialled successfully in a number of areas across the country …* *Medical examiners would scrutinise all deaths except for stillbirths (for legal reasons) and any death that requires a coroner investigation.* *However, the MBRRACE confidential enquiries provide independent scrutiny of all maternal deaths and topics related to stillbirths and neonatal deaths,*	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015) **National Medical Examiner** NHS England, 'The national medical		

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		taken to do so without delay. Action: the Department of Health. (March 2015)	*which is sufficient to learn national lessons for improvement of care." (p. 94)* Hansard – September 2023 *"We have already committed to moving medical examiners to a statutory basis and will table secondary legislation on that shortly. It will ensure that deaths not reviewed by a coroner are investigated in all medical settings, in particular extending coverage in primary care, and will enter into force in April." (col 36-37)*	examiner system' **Hansard** HC Deb 4 September 2023, vol 737, cols 36-37		
Improving NHS culture and governance	**40**	Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health. (March 2015)				Medical examiners were introduced on a non-statutory basis from 2019 to provide independent scrutiny of the causes of all non-coronial deaths, to support the appropriate direction of deaths to the coroner. This includes neonatal death.
Improving NHS culture and governance	**41**	We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical	Department of Health response (July 2015): Accepted in principle. *"… there are actions in train, which go some way to meeting it. For example, the Serious Incident Framework published by NHS England and updated in March 2015, sets out details of when and how*	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015)		

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		Royal Colleges, the Royal College of Nursing, the Royal College of Midwives. (March 2015)	*investigations – including independent investigations - should be undertaken.* *As noted earlier, the Government are accepting the Public Administration Select Committee's recommendation to establish an independent patient safety investigation function for the NHS … we will be taking this forward … One of the tasks will be …to consider how the new function will operate alongside and complement existing bodies that relate to NHS … organisations that may be carrying out other reviews (including professional and external reviews)."* (p. 95)	NHS England, 'Serious Incident framework' **Independent Patient Safety Investigation Service / HSIB** 'Healthcare Safety Investigation Branch (HSIB) Expert Advisory Group'		
Improving NHS culture and governance	**42**	We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor.	Department of Health response (July 2015): *"The Government will consult on proposals to extend the regulations that set out requirements for notifications to cover the commissioning of external investigations."* (p. 75)	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015)		With regards to disseminating learning, In March 2019 CQC published Learning from Deaths: A review of the first year of NHS trusts

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		(March 2015)	Although unable to find government proposal, the Care Quality Commission webpage states that disclosure of commissioning any external revies should be disclosed as a "*matter of course*" which is unclear whether this is a statutory obligation or suggested guidance. Also this does not form part of the notifications that are meant to go to the Care Quality Commission.	**Care Quality Commission Website** Care Quality Commission, 'How we manage our relationship with NHS trusts' (last updated 12 May 2022) Care Quality Commission, 'Notifications' (last updated 7 November 2023)		implementing the national guidance.
Improving NHS culture and governance	**43**	We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, High Quality Care for All, and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and	Department of Health (July 2015): Accepts this recommendation. *"The Government will continue to prioritise the quality of care, and will hold its arms-length bodies to account on their commitments to reinforce and improve the quality of care. This will be a key focus*	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015)		In April 2021, the NQB published a position statement on Managing Risks and Improving Quality through

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		post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health. (March 2015)	*of the newly re-established National Quality Board, in providing leadership for quality across the NHS."* (p. 96)	NHS England, 'National Quality Board: Shared Commitment to Quality'		Integrated Care Systems. Alongside this the NQB and NHSEI have progressed a wide portfolio of quality guidance and tools to support ICSs as they develop. These include: • A refreshed Shared Commitment to Quality (April 2021) to provide a common definition and vision of quality for those working in health and care systems. It uses the existing Darzi-based

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						definition of high-quality care as being safe, effective, and providing a positive experience, with a greater emphasis on population health and health inequalities. • Preparing for Handover: Managing Quality Risks and Improving Quality through Integrated Care Systems in ICSs (October

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						2021), which summarises the key responsibilities and considerations for ICSs relating to quality and to aid the operational transition from CCGs to ICBs. It refreshes the 2012 NQB handover publication that supported quality in the transition from PCTs to CCGs. • A refreshed framework for System Quality

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						Groups (SQG) (B0894-nqb-guidance-on-system-quality-groups.pdf (england.nhs.uk) which refreshes existing NQB guidance on 'Quality Surveillance Groups' and provides clarity on SQGs and broader ICS quality governance structures in which key health and care partners come together to share

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						intelligence and risk on quality of care.
Improving NHS culture and governance	**44**	This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We believe that this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current and former health service staff to cooperate. Action: the Department of Health. (March 2015)	Department of Health response (July 2015): *A new Independent Patient Safety Investigation Service will conduct independent, expert-led investigations into patient safety incidents. (p. 82)*	Department of Health, Learning not Blaming, (White Paper, Cm 9113, 2015) **Independent Patient Safety Investigation Service / HSIB** 'Healthcare Safety Investigation Branch (HSIB) Expert Advisory Group'		

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21 THE LIVERPOOL COMMUNITY HEALTH INDEPENDENT REVIEW

21.1 Introduction

An Independent Review commissioned by the then NHS Improvement to look into issues at Liverpool Community Health NHS Trust from November 2010 to December 2014. The Independent Review was chaired by Dr Bill Kirkup CBE. Its report was published in February 2018.

Liverpool Community Health NHS Trust was created as a new organisation in 2010. In 2014, following the publication of a critical Care Quality Commission Report in late 2014, the board of the Trust commissioned a review by Capsticks Solicitors LLP. Their report was published in March 2016 and generated concern about the quality of the healthcare being provided by Liverpool Community Health NHS Trust.

The Independent Review was tasked with:

- Reviewing the outcomes for patients cared for by Liverpool Community Health NHS Trust and its predecessor organisation from November 2010 to December 2014.
- Reviewing the oversight of Liverpool Community Health NHS Trust by the NHS Trust Development Authority, NHS England, other regulators and commissioners, and their response to concerns arising from the operation of the Trust.
- Making recommendations on the lessons to be learned for the wider NHS.

The Independent Review identified a number of significant failings in care quality. A large new NHS Trust had been established from scratch with an inexperienced Board and senior staff, and which had received inadequate scrutiny. Unnecessary harm was caused to patients over the years, and staff were in some cases bullied and harassed when they tried to raise concerns.

The Inquiry made 10 recommendations. NHS Improvement responded to these in a series of board papers, not all of which appear to be publicly available. Following publication of the February 2018 report, Mersey Care NHS Foundation Trust identified new evidence of possible failings in care provided by Liverpool Community NHS Trust. In light of this, the Government constituted a new independent investigation, again to be led by Dr Kirkup, the terms of reference for which were published on 16 July 2020. The independent investigation is ongoing.

21.2 The Liverpool Community Health Independent Review: Table of Recommendations

The Liverpool Community Health Independent Review					
Type of Recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
Improving NHS culture and governance	1	In approving Trust Board appointments, NHS Improvement should take note of the level of experience of appointees and the level of risk in the Trust, and should ensure a system of support and mentorship for Board members where indicated. Action: NHS Improvement.	In the March 2018 Board Paper, Mark Dalton, the then CEO of NHS Improvement said: • NHS Improvement had a statutory role in appointing chairs and non-executive directors to NHS trust boards. Members of the relevant committees would continue to expressly take into account the experience of prospective appointees, and the level of risks in a trust, when considering whether to approve such appointments. • For NHS foundation trusts, NHS Improvement did not have a statutory role in approving any Board appointments, nor in the executive appointment process. • The role NHS Improvement played in board appointments was not sufficiently clear. Mr Dalton had asked his team to review NHS Improvement's role in board appointments and report back by May 2018. • NHS Improvement would work with other national bodies, including Health Education England and NHS Leadership Academy, to develop a latent	NHS Improvement Board Paper for meeting on 22 March 2018 (https://www.england.nhs.uk/wp-content/uploads/2019/09/Response_to_recommendations_review_Liverpool_Community_Health_NHS_Trust.pdf). NHS Improvement Board Paper for meeting on 27 September 2018 (https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1860_Kirkup_update.pdf). Regional Talent Boards – NHS	

The Liverpool Community Health Independent Review					
Regulation and oversight of NHS managers			management and professional development offer for the provider sector. The report on NHS Improvement's role in board appointments was presented in a private session of the NHS Improvement Board in May 2018. In the September 2018 Board Paper, it was noted: • Development of a new talent management strategy for board level appointments was underway, including work on the development of new guidance on 'Appointments to the board'. • Roll-out of regional talent boards was underway, led by the NHS Leadership Academy. • Work to design a National Talent Board was ongoing. Six regional talent boards appear to have been created.	Leadership Academy (https://www.leadershipacademy.nhs.uk/aspiretogether/)	
Improving NHS culture and governance	2	In assessing the level of risk facing a Trust, regulators and oversight organisations should take into account the cumulative impact of relevant factors, including a newly established	In the March 2018 Board Paper, Mark Dalton, the then CEO of NHS Improvement said: • NHS Improvement would work with other national organisations to conduct exercises which 'stress	NHS Improvement Board Paper for meeting on 22 March 2018 (https://www.engla	

The Liverpool Community Health Independent Review

		organisation, inexperienced Board, cost improvement targets and service acquisitions. Action: Care Quality Commission, NHS Improvement, NHS England.	tested' its current oversight approach against a range of example scenarios, the findings of which would be used to improve its approach to assessing risk. • NHS Improvement would seek additional assurance where appropriate that robust and clinically-led processes had been followed in the development of cost improvement plans. • Regional teams would conduct a rapid review of the level of experience and risk in community trust. In the July 2018 Board Paper, it was said that NHS Improvement had provided close support and challenge to trusts to finalise their operational plans for 2018/19. NHS Improvement also said that the rapid view of risk levels and experience in community trusts had been carried out in March, with no significant issues raised in the vast majority of cases. In the September 2018 Board Paper, NHS Improvement said a review of soft intelligence was ongoing to identify if there were any early signals that quality was at risk, and that its policy team had undertaken a detailed review of risk in standalone community providers.	nd.nhs.uk/wp-content/uploads/2019/09/Response_to_recommendations_review_Liverpool_Community_Health_NHS_Trust.pdf). NHS Improvement Board Paper for meeting on 26 July 2018 (https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1845_Kirkup_update.pdf). NHS Improvement Board Paper for meeting on 27 September 2018 (https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1860_Kirkup_update.pdf).	

The Liverpool Community Health Independent Review					
Improving NHS culture and governance	3	Regulators and oversight organisations should review how they work together jointly at regional and national level, and implement mechanisms to improve the use of information and soft intelligence more effectively. Action: Care Quality Commission, NHS Improvement, NHS England.	In the March 2018 Board Paper, Mark Dalton, the then CEO of NHS Improvement said: • A formal programme of work was underway to more systematically distinguish between where it made sense to integrate work with NHS England, where it made sense to collaborate more closely and where it made sense to remain distinct. • NHS Improvement was committed to sharing information and soft intelligence more effectively with other national bodies. • NHS Improvement would launch a programme of work to transform its IT infrastructure. From 1 April 2019, NHS Improvement and NHS England worked together as a single organisation. NHS England and NHS Improvement were merged on 1 July 2022.	NHS Improvement Board Paper for meeting on 22 March 2018 (https://www.england.nhs.uk/wp-content/uploads/2019/09/Response_to_recommendations_review_Liverpool_Community_Health_NHS_Trust.pdf).	

The Liverpool Community Health Independent Review					
Improving NHS culture and governance **Regulation and oversight of NHS managers**	4	Regulators and oversight organisations should ensure that, during both local and national reorganisations and reconfigurations, performance and other service information is properly recorded and communicated to successor organisations. Action: Care Quality Commission, NHS Improvement, NHS England.	In the March 2018 Board Paper, Mark Dalton, the then CEO of NHS Improvement said: • NHS Improvement would work with NHS England to develop a more integrated approach to regional oversight and would address the need to ensure relevant information is passed on to successor organisations locally. • NHS Improvement would review its standard operating procedures for its regulatory support committees to ensure information is collected and codified in a way that supports timely and effective transfers in the event of any changes to national functions. In the May 2018 Board Paper, NHS Improvement said its governance team had reviewed the information management and record-keeping arrangements for all formal decision-making committees and confirmed that these met best practice. From 1 April 2019, NHS Improvement and NHS England worked together as a single organisation. NHS England and NHS Improvement were merged on 1 July 2022.	NHS Improvement Board Paper for meeting on 22 March 2018 (https://www.england.nhs.uk/wp-content/uploads/2019/09/Response_to_recommendations_review_Liverpool_Community_Health_NHS_Trust.pdf). NHS Improvement Board Paper for meeting on 24 May 2018 (https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1831_Kirkup_update.pdf).	
Regulation and oversight of NHS managers	5	The Department of Health should review the working of the Care Quality Commission fit and proper person test, to ensure that concerns over the capability and conduct of NHS executive and	The Kark Review ('A review of the Fit and Proper Person Test') was commissioned in July 2018 and reported in November 2019.	The Kark Review of the Fit and Proper Person Test, November 2018	

The Liverpool Community Health Independent Review					
		non-executive Directors are definitively resolved and the outcome reflected in future appointments. Action: Department of Health.		(https://assets.publishing.service.gov.uk/media/5c937b7e40f0b633f5bfd89c/kark-review-on-the-fit-and-proper-persons-test.pdf).	
Improving patient safety	6	Organisations taking on former Liverpool Community Health NHS Trust services should review handling of previous serious incidents to ensure they have been properly investigated and lessons learned. Action: Trusts providing former Liverpool Community Health NHS Trust services.	In the March 2018 Board Paper, Mark Dalton, the then CEO of NHS Improvement said: • NHS Improvement was providing advice to the provider that had taken on the most former Liverpool Community Health NHS Trust staff, to commission and conduct an independently-led review into previous serious incidents. • NHS Improvement would advise other trusts that had taken on former Liverpool Community Health NHS Trust services to take similar action. In the May 2018 Board Paper, NHS Improvement said it had written to all such providers to provide detailed guidance on the implementation of this recommendation, and for them to share the outcomes and evidence gathered, as well as actions taken, with NHS Improvement. NHS Improvement also said that NHS England and NHS Improvement had contributed additional funding to Mersey Care to enable this to be carried out.	NHS Improvement Board Paper for meeting on 22 March 2018 (https://www.england.nhs.uk/wp-content/uploads/2019/09/Response_to_recommendations_review_Liverpool_Community_Health_NHS_Trust.pdf). NHS Improvement Board Paper for meeting on 24 May 2018 (https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1831_Kirkup_update.pdf).	

The Liverpool Community Health Independent Review					
Improving NHS culture and governance	7	Organisations taking on former Liverpool Community Health NHS Trust staff as part of service transfers should review the handling of disciplinary and whistleblowing cases urgently to ensure that they have been properly and appropriately resolved. These organisations should ensure that staff are not placed back into working relationships previously the subject of bullying and harassment. Action: Trusts providing former Liverpool Community Health NHS Trust services.	In the March 2018 Board Paper, Mark Dalton, the then CEO of NHS Improvement said: • The provider that had taken on the most former Liverpool Community Health NHS Trust staff had confirmed its intentions for an independent practitioner to undertake a review of whistleblowing records, with an independent HR practitioner to review any disciplinary investigations. • NHS Improvement would work with all relevant advisers to ensure that this recommendation was implemented. In the May 2018 Board Paper, NHS Improvement said it had written to all such providers to provide detailed guidance on the implementation of this recommendation, and for them to share the outcomes and evidence gathered, as well as actions taken, with NHS Improvement. NHS Improvement also said that NHS England and NHS Improvement had contributed additional funding to Mersey Care enable this to be carried out.	NHS Improvement Board Paper for meeting on 22 March 2018 (https://www.england.nhs.uk/wp-content/uploads/2019/09/Response_to_recommendations_review_Liverpool_Community_Health_NHS_Trust.pdf). NHS Improvement Board Paper for meeting on 24 May 2018 (https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1831_Kirkup_update.pdf).	
Improving patient safety	8	Reconfigured Liverpool Community Health NHS Trust services should be reviewed after a year to ensure that the services are now safe and effective. Action: NHS Improvement, NHS England.	In the March 2018 Board Paper, Mark Dalton, the then CEO of NHS Improvement said that he had agreed with Dr Kirkup that a review of relevant services would take place by 31 March 2019, using the joint quality oversight infrastructure established since the period covered by the report. A review report was presented to the NHS England and NHS Improvement Board common meeting in January 2020. In relation to Mersey Care Foundation Trust, which had taken	NHS Improvement Board Paper for meeting on 22 March 2018 (https://www.england.nhs.uk/wp-content/uploads/2019/09/Response_to_recommendation	

The Liverpool Community Health Independent Review					
			on the most services previously provided by Liverpool Community Health NHS Trust it was found that while improvements had been made, concerns remained.	s_review_Liverpool_Community_Health_NHS_Trust.pdf). Board Paper for NHS England/NHS Improvement meeting on 30 January 2020 (https://www.england.nhs.uk/wp-content/uploads/2020/01/board-meeting-item-8-kirkup-a-report.pdf). Appendices to Board Paper for NHS England/NHS Improvement meeting on 30 January 2020 (https://www.england.nhs.uk/wp-content/uploads/2020/01/board-meeting-item-8-kirkup-b-annex.pdf).	

The Liverpool Community Health Independent Review					
	9	Health services in HMP Liverpool should be subject to urgent review to ensure that future arrangements are fit for purpose and will be effectively monitored. Action: NHS England.	Implementation unknown.		
	10	NHS England should review the arrangements for commissioning prison health services to ensure that these are safe and effective. Action: NHS England.	Implementation unknown.		

22 WILLIAMS REVIEW INTO GROSS NEGLIGENCE MANSLAUGHTER IN HEALTHCARE

22.1 Introduction

The Williams review was launched on 6 February 2018 by the Secretary of State for Health as a rapid policy review into gross negligence manslaughter in healthcare. It was set up following the case of Dr Bawa-Garba, which involved the death of a young boy, following which Dr Bawa-Garba was struck off (which she later successfully appealed). The review was set up to consider the wider patient safety impact resulting from concerns among healthcare professionals that simple errors could result in prosecution for gross negligence manslaughter, even if they occur in the context of broader organisation and system failings. In particular, there was concern that this fear had had a negative impact on healthcare professionals being open and transparent should they be involved in an untoward event, as well as on their reflective practice, both of which are vital to learning and improving patient care.

The review was conducted by Professor Sir Norman Williams and his report was published in June 2018. The report can be viewed online.

The Secretary of State accepted the recommendations in full (please see the statement for more detail) but no specific plan or response was published by the government, with implementation being left to various other bodies. There is written evidence available from the Department of Health and Social Care from October 2018 which included a compilation of steps being taken by the relevant bodies to implement recommendations, which is referred to below.

There is some overlap with the Francis Review and some documents provided are in response to both.

22.2 Williams Review: Table of Recommendations

Williams Review						
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**	**DHSC Comments**
	1	**An agreed and clear position on the law on gross negligence manslaughter.** (June 2018) Action 1.1: A working group should be set up to set out a clear explanatory statement of the law on gross negligence manslaughter. This working group should involve, at a minimum, representatives from the Crown Prosecution Service, the coroner services, Treasury Counsel and healthcare defence organisations. Action 1.2: All relevant organisations, including, if appropriate, the Director of Public Prosecutions, should produce or update guidance on gross negligence manslaughter in light of the explanatory statement set out by the working group in 1.1. This will promote a consistent understanding of where the threshold for prosecution for	Accepted by the government (June 2018). Action 1.1: Department of Health and Social Care to coordinate – a multi-disciplinary working group has been set up to support the Crown Prosecution Services to update the explanatory note on gross negligence manslaughter (22 October 2018). The Crown Prosecution Service have published a legal guidance document on gross negligence manslaughter dated 14 March 2019. Action 1.2: All organisations with relevant guidance to action. See 1.1 above.	**Written evidence from Department of Health and Social Care** (22 October 2018) The Crown Prosecution Service have published a legal guidance document on gross negligence manslaughter (14 March 2019)		

Williams Review						
		gross negligence manslaughter lies.				
Improving patient safety	**2**	**Improving assurance and consistency in the use of experts in gross negligence manslaughter cases.** (June 2018) Action 2.1: The Academy of Royal Medical Colleges, working with professional regulators, healthcare professional bodies and other relevant parties, should lead work to promote and deliver high standards and training for healthcare professionals providing an expert opinion or appearing as expert witnesses. These standards should set out what, in the Academy's opinion, constitutes appropriate clinical experience expected of healthcare professionals operating in such roles. Healthcare professionals providing an expert opinion or appearing as an expert witness should have relevant clinical experience and, ideally, be in current clinical practice in the area under consideration. Additionally, they should	Accepted by the government (June 2018). Action 2.1: For the Academy of Royal Medical Colleges to implement. The Academy of Royal Medical Colleges has set up an expert group comprising representatives from professional bodies and other relevant groups to develop standards and training for practitioners providing expert advice. The expert group has two tasks: - To produce a framework of standards/good practice which will incorporate the recommendations of the Williams Review - Subsequently, developing proposals for training based on the agreed standards/good practice. (October 2018) The Academy of Royal Medical Colleges produced guidance in May 2019. Action 2.2:	**Written evidence from Department of Health and Social Care** (22 October 2018) **Academy of Royal Medical Colleges guidance "Acting as an expert or professional witness: Guidance for healthcare professionals"** (May 2019)		

Williams Review						
		understand the legal requirements associated with being an expert witness (including the requirement to provide an objective and unbiased opinion). Action 2.2: Healthcare professionals should be supported and encouraged to provide an expert opinion where it is appropriate for them to do so. Healthcare professional bodies, including Royal Colleges and professional regulators, should encourage professionals to undertake training to become expert witnesses, and employing organisations should be prepared to release staff when they are acting as expert witnesses. Action 2.3: Professional representative bodies and regulators should recognise acting as an expert witness as part of a healthcare professional's revalidation or continuous professional development process.	For the police, Crown Prosecution Service, and regulatory bodies to implement. See 2.1 re standards / training. <u>Action 2.3:</u> For professional bodies, Royal Colleges, and regulatory bodies to implement. To follow from 2.1 re standards and training. <u>Action 2.4:</u> For regulatory bodies to implement. To follow from 2.1 re standards and training <u>Action 2.4:</u> For the Academy of Royal Medical Colleges to implement. See 2.1 re standards and training.			

Williams Review						
		Action 2.4: Although our terms of reference were limited to gross negligence manslaughter, the review heard evidence of more general concerns about experts. This should be reflected in the Academy's work to develop training for healthcare professionals acting in this capacity.				
Improving patient safety	**3**	**Consolidating expertise of gross negligence manslaughter in healthcare settings in support of investigations.** (June 2018) Action 3.1: The Chief Coroner should consider revising the guidance on gross negligence manslaughter in Law Sheet no 1 in light of the explanatory statement set out by the working group under 1.1. We expect coroners will routinely consider this guidance in assessing the facts on whether or not a referral for a criminal investigation should be made. Action 3.2: Building on the work of the Homicide Working Group, police forces across England	Accepted by the government (June 2018). Action 3.1: For the Ministry of Justice to implement. See 1.1 above. Law Sheet No 1 was last updated on 21 September 2021. Action 3.2: For the National Police Chiefs' Council to implement. The National Policing Homicide Working Group is updating its guidance on murder investigations and sharing best practice on investigating potential gross negligence manslaughter cases. (October 2018)	**Written evidence from Department of Health and Social Care** (22 October 2018) **Chief Coroner's Law Sheet No 1 (21 September 2021)** **Major Crime Investigation Manual: Published November 2021** **Memorandum of**		*Action 3.4* - A new MOU is being developed to replace the 2006 protocol ('Investigating patient safety incidents involving unexpected death or serious untoward harm: a protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health & Safety Executive').

Williams Review						
		should consolidate their expertise on gross negligence manslaughter by a healthcare professional through the creation of a virtual specialist unit. This unit would support senior investigating officers by making available the experience of previous gross negligence manslaughter cases in the early stages of an investigation. Action 3.3: Advice to senior investigating officers should be updated to reflect the explanatory statement on gross negligence manslaughter set out by the working group (1.1) and the standards for healthcare professionals providing an expert opinion or appearing as expert witnesses (2.1). Action 3.4: A new memorandum of understanding should be agreed between relevant bodies, including the College of Policing, the Crown Prosecution Service, the Care Quality Commission, Health and Safety Executive, the Healthcare Safety Investigation Branch, and professional	Action 3.3: For the National Police Chiefs' Council to implement. Senior Investigating Officer guidance will be updated in line with explanatory statement on the law and improvements to expert witness provisions. (October 2018) The National Police Chiefs' Council published updating guidelines in November 2021 which refer to the Crown Prosecution Service explanatory note in 1.1. Action 3.4: Department of Health and Social Care to coordinate. A working group has been set up to develop a memorandum of understanding setting the roles of key organisations in investigating deaths in healthcare settings. This group includes the Department of Health and Social Care, the Care Quality Commission, NHS Improvement, the police and the Health and Safety Executive. (October 2018) There is a 2019 Memorandum of Understanding between the Care Quality Commission and the National Police Chiefs' Council regarding 'investigating specific incidents involving	**Understanding: " Investigating specific incidents involving avoidable harm to users of health and social care services in England or where users of health and social care services have been exposed to a significant risk of exposure to avoidable harm: a protocol for liaison and effective communication between the Care Quality Commission (CQC) and National Police Chiefs' Council (NPCC)"**		

Williams Review						
		regulators, in relation to the investigation of deaths in a healthcare setting. As a minimum this memorandum of understanding should establish a common understanding of the respective roles and responsibilities of the organisations involved, support effective liaison and communications between these organisations, and cover what is expected of expert witnesses, in particular that they should consider the role of systemic and human factors in the provision of healthcare. Action 3.5: Signatories to the memorandum of understanding should disseminate its contents in order to promote a greater understanding of legal issues among healthcare professionals and of healthcare issues (including systemic and human factors) among prosecuting authorities, the police and coroner services. This would help support the development of a "just culture" in healthcare, which	avoidable harm to users of health and social care services in England or where users of health and social care services have been exposed to a significant risk of exposure to avoidable harm' but this does not specifically relate to deaths only nor does it include all the relevant bodies. Action 3.5 Department of Health and Social Care to coordinate. See 3.4 above.	Published in 2019		

Williams Review						
		recognises both systemic factors and individual accountability.				
Improving patient safety	**4**	**Improving the quality of local investigations.** (June 2018) Action 4.1: Where a suspected gross negligence manslaughter case in a healthcare setting has been referred to the Crown Prosecution Service, the Care Quality Commission must be informed so that it can consider whether to carry out a parallel, but separate, investigation of the healthcare provider to determine the role of systemic and human factors in the incident and to identify any changes which might need to be made. The Care Quality Commission should also consider the findings of its inspection in deciding whether to undertake any follow up action in relation to the provider and/or any wider review of system issues. The relationship between a criminal investigation and any parallel Care Quality Commission inspection should be set out in the	Accepted by the government (June 2018). Action 4.1: Care Quality Commission to implement. See 3.4 regarding the memorandum of understanding. Action 4.2: Care Quality Commission to implement. Following the Learning from Deaths report, national guidance for NHS acute, community and mental health trusts was published. The Care Quality Commission has strengthened its assessment of how trust learn from deaths through a tool (introduced in September 2017) as part of the well-led assessment. This reflects good practice set out in both the national guidance and the recently published Guidance for NHS trusts on working with bereaved families and carers. Guidance will be expanded to primary care and ambulance trusts. Care Quality Commission will ensure monitoring and inspection of these sectors reflects the expectations. There is no similar guidance for independent health care providers. However, as	**Written evidence from Department of Health and Social Care** (22 October 2018) **Patient Safety Incident Response Framework**: Updated 14 September 2022 **NHS 'Learning from Deaths' Tool** **Health and Care Act 2022 Part 4, establishing Health Service Safety Investigations Body**		

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		memorandum of understanding under 3.4. Action 4.2: There must be a thorough local investigation of all unexpected deaths in healthcare settings, both in the NHS and in the independent sectors. The Care Quality Commission should consider the effectiveness of such investigations as part of its inspection programme of healthcare providers. Action 4.3: In the case of NHS organisations, investigations into unexpected deaths should be carried out in line with NHS Improvement's Serious Incident Framework. In particular family members, carers or advocates must be involved and supported (e.g. through family liaison) from the outset and be kept informed of progress and the outcome. Investigations must be expertly and objectively overseen and, where appropriate, independently-led. A member of the healthcare provider's Board must be appointed to be responsible for ensuring the	part of the Care Quality Commission's well-led assessments they look at whether there are robust systems and processes for learning, continuous improvement and innovation. (October 2018) <u>Action 4.3:</u> NHS Improvement to implement. NHS Improvement will take into account the review's recommendations in planned revisions to the Serious Incident Framework. This will be updated by the end of the 2018/19 financial year. (October 2018) The Serious Incident Framework is now being replaced with the Patient Safety Incident Response Framework (published 14 September 2022). <u>Action 4.4:</u> For healthcare providers to implement. See 4.3. <u>Action 4.5:</u> For Department of Health and Social Care to implement.			

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		Serious Incident Framework is followed in relevant investigations. The outcome of such investigations should be reported to the Board and shared with the relevant regulatory, statutory, advisory and professional bodies. A similar methodology for investigations should be adopted by private healthcare providers. Action 4.4: Healthcare providers should ensure that people conducting investigations have received appropriate training, including on equality and diversity. NHS Improvement's Serious Incident Framework should include guidance on how to consider equality and diversity considerations in investigations, including adherence to appropriate equality and diversity standards such as WRES33 (Workforce Race Equality Standards) standards for the NHS. Wherever possible the investigation team should include Black, Asian and Minority Ethnic (BAME) representation.	The Health Service Safety Investigations Bill was published in draft in September 2017 and underwent pre-legislative scrutiny by a Joint Committee in Parliament earlier this year (2018). The Department of Health and Social Care plans to publish the Government response to the Committee's report in November 2018 and revise the Bill in light of the scrutiny process, with a view to introduction of the Bill as soon as parliamentary time allows. (October 2018) The Health and Care Act 2022 created the Health Service Safety Investigations Body (Part 4 of the Act). <u>Action 4.6:</u> For Royal Colleges, professional representative bodies and healthcare providers to implement.			

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		Action 4.5: Proposals for the establishment of Healthcare Safety Investigation Branch as an Executive Non-Departmental Public Body should be implemented at the earliest opportunity. The Healthcare Safety Investigation Branch will support improved practice across the NHS by undertaking exemplar investigations and supporting the development of skilled NHS investigations. Action 4.6: Royal Colleges, professional representative bodies and healthcare providers should review the availability of independent support for staff involved in legal and regulatory proceedings.				
Improving NHS culture and governance	**5**	**Reflective material** (June 2018) Action 5.1: The Royal Colleges, through the Academy, and professional regulators working with appropriate professional bodies should review and, if necessary, amend guidance on how healthcare professionals carry out reflection, stressing the	Accepted by the government (June 2018). Action 5.1: For the Academy of Medical Royal Colleges to implement. The Academy of Medical Royal Colleges has published two pieces of work on reflective practice – guidance developed jointly with	**Written evidence from Department of Health and Social Care** (22 October 2018) **Academy of Medical Royal Colleges**		Action 5.3 - Work is being done in conjunction with the overhaul of all professional regulators' underpinning legislation. Work to reform the General Medical Council's legislation is underway, however we would not expect such legislation to

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		value of reflective practice in supporting continuous professional development. Guidance on carrying out reflection should take a consistent approach across all healthcare professional groups. Action 5.2: Both prosecuting authorities and professional regulators have been clear that they would be unlikely to use a healthcare professional's reflective material either for a criminal investigation or in considering a registrant's fitness to practise. The professional regulators should clarify their approach to reflective material through guidance. Action 5.3: Those professional regulators that have a power to require information from registrants for the purposes of fitness to practise procedures should have this power modified to exclude reflective material. Registrants will still be expected to cooperate with their regulator in line with their code of practice and to be open and honest with	Conference of Postgraduate Medical Deans, the General Medical Council, and the Medical Schools Council; and a Reflective Practice Toolkit developed with the Conference of Postgraduate Medical Deans (October 2018). Action 5.2: For regulatory bodies to implement. Action 5.3: For Department of Health and Social Care to implement. The Government is considering legislative options to remove the right to require reflective practice from those regulators that currently hold such a power (General Medical Council and General Optical Council). This requires a S60 statutory instrument. Subject to parliamentary time being available this could take circa 18 months. (October 2018) This does not appear to have taken place.	**Toolkit**: Published August 2018 **Academy of Medical Royal Colleges Joint Guidance on Reflective Practice:** Published August 2018		be in force before 2025, at the earliest.

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		patients (or where appropriate the patient's advocate, carer or family) when something goes wrong with their treatment or care (the professional duty of candour).				
Improving patient safety	**6**	**Right of appeal against fitness to practise decisions.** (June 2018) Action 6.1: The Professional Standards Authority should retain its right to appeal a decision of a fitness to practise panel to the High Court on the grounds of insufficient public protection. The duplicate power provided to the General Medical Council to appeal decisions of the Medical Practitioners Tribunal Service to the High Court should be removed. This will ensure a consistent approach to appeals across healthcare professions that are statutorily regulated. Action 6.2: Ahead of the legislative change needed to remove its power of appeal, the General Medical Council should review its processes for deciding when to refer a decision of the	Accepted by the government (June 2018). Action 6.1: For Department of Health and Social Care to implement. The Government is considering legislative options to remove the General Medical Council's right to appeal decisions of the Medical Practitioners Tribunal Service. This requires a S.60 statutory instrument. Subject to parliamentary time being available this could take circa 18 months. (October 2018) This does not appear to have taken place and the General Medical Council retains its power to appeal decisions. Action 6.2:	**Written evidence from Department of Health and Social Care** (22 October 2018) **General Medical Council Guidance on section 40A Appeals**		Work is being done in conjunction with the overhaul of all professional regulators' underpinning legislation. Work to reform the General Medical Council's legislation is underway, however we would not expect such legislation to be in force before 2025, at the earliest.

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		Medical Practitioners Tribunal Service so that it is transparent and understood by all parties and involves a group or panel decision, as opposed to lying solely with the Registrar.	For General Medical Council and Professional Standards Authority. The Professional Standards Authority is carrying out a review of the General Medical Council's use of its appeal right as part of its annual review (October 2018). The General Medical Council has published recent guidance (postdating 2019) regarding appeals pursuant to section 40A of the Medical Act 1983.			
Improving patient safety	**7**	**Consistency of fitness to practise decisions across professional regulators.** (June 2018) Action 7.1: Among professionals there is little understanding of what actions by a healthcare professional might lead to the public losing confidence in the profession. The Professional Standards Authority, working with professional regulators, should review how the impact on public confidence is assessed in reaching fitness to practise decisions about individual healthcare professionals, and develop guidance to support	Accepted by the government (June 2018). Action 7.1: For the Professional Standards Authority to implement. The Professional Standards Authority is developing proposals to better understand how public confidence in a profession is assessed when reaching fitness to practise decisions. Advice was published in response by the Professional Standards Authority in April 2019. Action 7.2: For the Professional Standards Authority to implement.	**Written evidence from Department of Health and Social Care** (22 October 2018) **Professional Standards Authority Advice: "How is public confidence maintained when fitness to practise decisions are made?"**		

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		consistent decision making in this area. Action 7.2: The Professional Standards Authority should review the outcomes of fitness to practise cases relating to similar incidents and circumstances considered by different regulators. This review should seek to determine the extent and reasons for different fitness to practise outcomes in similar cases and, if appropriate, recommend changes to ensure greater consistency. Action 7.3: We recommend that professional regulators ensure that the healthcare professionals they rely upon for an expert opinion in fitness to practise cases have satisfied the requirements set out in recommendation 2.1.	The Professional Standards Authority is developing proposals to review the outcomes of similar cases (October 2018). Guidance was published in June 2019. Action 7.3: For professional regulators. Follows from 2.1 re standards and training.	Published April 2019 **Professional Standards Authority Report "Developing a methodology to assess the consistency of fitness to practise outcomes"** Published June 2019		
Improving NHS culture and governance	**8**	**Diversity in fitness to practise proceedings** (June 2018) Action 8.1: The review supports the Professional Standards Authority's intention to introduce,	Accepted by the government (June 2018). Action 8.1:	**Written evidence from Department of Health and**		

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		as part of its Standards of Good Regulation, equality and diversity standards for professional regulators. Action 8.2: Professional regulators should ensure that fitness to practise panel members have received appropriate equality and diversity training.	For the Professional Standards Authority to implement. The Professional Standards Authority has consulted on a revised set of Standards of Good Regulation to include equality and diversity standards for regulators, which will be published in late November (October 2018). Updated Standards of Regulation were published in February 2019. Action 8.2: For regulatory bodies and the Professional Standards Authority to implement. The new standards (see 8.1) will enable the Professional Standards Authority to look at the training given to panel members and support given to patients and families. (October 2018)	**Social Care** (22 October 2018) **Standards of Good Regulation (Professional Standards Authority)** published February 2019		
Improving the ability to raise complaints and concerns	**9**	**Legal representation in fitness to practise proceedings** (June 2018) Action 9.1: The Professional Standards Authority should review whether the outcome of fitness to practise procedures is affected by the availability of legal representation of registrants. This needs to be considered alongside	Accepted by the government (June 2018). Action 9.1 For the Professional Standards Authority to implement. The Professional Standards Authority has begun collecting data on the legal representation in fitness to practice proceedings, and is scoping	**Written evidence from Department of Health and Social Care** (22 October 2018)		

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		broader proposals for the reform of professional regulation which seek to establish a less adversarial approach to fitness to practise issues through the use of undertakings and consensual disposal.	out work to review whether the outcome of fitness to practise procedures is affected by the legal representation of registrants (October 2018).			
Improving the ability to raise complaints and concerns	**10**	**Support for patients and families during fitness to practise proceedings** (June 2018) Action 10.1: Professional regulators should review and where necessary improve the support they provide to patients and family members whose care and treatment is an issue in fitness to practise proceedings against a healthcare professional.	Accepted by the government (June 2018). Action 10.1: For regulatory bodies and the Professional Standards Authority to implement. The Professional Standards Authority will assess the support that regulators provide to patients and family members whose care and treatment is an issue in fitness to practise proceedings against a healthcare professional through the annual review of performance (October 2018).	**Written evidence from Department of Health and Social Care** (22 October 2018)		

23 THE GOSPORT INDEPENDENT PANEL

23.1 Introduction

The Gosport Independent Panel was set up to address concerns raised by families over a number of years about the initial care of their relatives in Gosport War Memorial Hospital ('the hospital') and the subsequent investigations into their deaths.

The Panel was independent in terms of the scope and delivery of its Terms of Reference but was funded by the Department of Health (now Department of Health and Social Care) from January 2018. The Panel's Terms of Reference were announced in December 2014 and the Panel convened for the first time on 13 January 2015. The Panel's report was published on 20 June 2018 and was led by the Right Reverend James Jones KBE. The report can be viewed online.

The Panel's primary focus was to investigate the concerns raised by families in relation to the hospital and to add to public understanding of what happened at the hospital. Its role was to establish the facts rather than to make specific recommendations for policy and practice. However, there are a number of clear messages and lessons noted in the report which have been responded to by the Government, in a response document dated 21 November 2018. Those are summarised below.

It was noted by the Government that a number of issued raised by the Gosport Independent Panel also had been driven home in recent years by the cases of Mid Staffordshire and Morecambe Bay. Whilst these cases occurred after Gosport, the reports into them came before the Panel's conclusions, and therefore many of the measures taken are also relevant to Gosport.

23.2 The Gosport Independent Panel: Table of Recommendations

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Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**	**DHSC Comments**
Listening to patients, families and staff. 'Over the many years during which the families have sought answers to their legitimate questions and concerns, they have been repeatedly frustrated by senior figures … The obfuscation by those in authority has often made the relatives of those who died angry and disillusioned … When relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions' - Bishop James Jones, Foreword to the Panel Report. (June 2018)						
Improving patient safety	**1**	**Freedom to speak up and raising concerns:** The Report illustrates how clinical authority and a culture of hierarchy and silence was used to stifle the voices of staff and families. Nursing staff first raised concerns about the prescribing and administration of drugs in Gosport War Memorial Hospital in 1991. They were marginalised, and this was the first lost opportunity to prevent so many avoidable	The following key actions were suggested by the Government (November 2018): a. The Government will consider how best to strengthen protection for whistleblowers within the NHS in order to support patients, families and staff to raise concerns. b. The Government is committed to ensuring that where staff speak up (including 'whistleblowers') their concerns are investigated; and to making it more transparent in the way individual NHS	**Government response document to Gosport Report**, published November 2018		New regulations to protect job applicants in the NHS who have previously spoken up or 'blown the whistle' were created: *Employment Rights Act 1996 (NHS Recruitment - Protected Disclosure) Regulations 2018.*

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Improving the ability to raise complaints and concerns		deaths. (Report June 2018; summary from Government response, November 2018).	Trusts manage these cases. We will legislate, subject to Parliamentary time, to make all NHS Trusts in England publish Annual Reports on concerns of this type. c. The National Guardian will continue to champion those who speak up through her Network of Freedom to Speak Up Guardians, and will publish an independent, annual report to be laid before Parliament to showcase best practice, hold the Government and the system to account and advocate for change.			
Improving NHS culture and governance	**2**	**A culture of candour and consent:** The culture at Gosport was defensive, hierarchical, and ignored the concerns of patients and families. (Report June 2018; summary from Government response, November 2018).	The Government suggested the following action (November 2018): **The Care Quality Commission is reviewing how it assesses the statutory duty of candour.** In addition, all regulated healthcare professionals working in the United Kingdom (UK) have an individual professional duty of candour, which is a responsibility to be open and honest. This responsibility is set out in their respective professional codes of conduct. The professional regulators have published a joint statement on the professional duty of candour, which was promoted to health professionals, students and patients. Professional regulators have also included the	**Government response document to Gosport Report**, published November 2018 **Current joint guidance on the professional duty of candour** (updated 2022)		The Government announced a review of Duty of Candour in December 2023: Duty of candour review: terms of reference - GOV.UK (www.gov.uk)

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			duty of candour in the standards and guidance that health professionals are expected to meet at all times and have worked to embed these standards and guidance in practice.			
Improving NHS culture and governance	**3**	**A culture that listens, learns, and changes.** Among the many things that went wrong at Gosport was a failure of systems and of culture. The protections against poor care that organisations should bring to bear did not work; nor did those that should have been rooted in the behaviour and professionalism of those working in and running the hospital. The systems and culture at Gosport failed to stop care from moving to an unacceptable place, leading to tragic outcomes for patients and their families. (Report June 2018; summary from Government response, November 2018).	The government recommended the following key actions (November 2018): **The National Guardian has started to take a more active approach in looking at how organisations handle concerns raised by staff who speak up and will continue to implement its approach for staff in NHS Trusts**. An approach is recommended to ensure that all feedback is taken seriously, whether it: • is prompted or unprompted; • involves raising concerns, making complaints or Speaking Up; • is raised by service users, their families or staff; or • is identified independently by, for example, organisations like the Care Quality Commission, the Healthcare Safety Investigation Branch, or NHS Resolution.	**Government response document to Gosport Report**, published November 2018		NHS updated guidance on: a. speaking up "Freedom to speak up policy in the NHS", June 2022: PAR1245i-NHS-freedom-to-speak-up-national-Policy-eBook.pdf (england.nhs.uk) b. Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services, June 2022: B1245_ii_NHS-freedom-to-speak-up-guide-eBook.pdf (england.nhs.uk)

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			The Department of Health and Social Care therefore intends to publish a strategy for improving the way feedback is managed and used in the NHS (November 2018). The government also commented 'We believe it important to provide greater support to those staff who do 'Speak Up', and we shall work with the National Guardian Office to investigate the appropriateness of engaging with 'these cases at an earlier stage.' (see recommendation 1, above).			
Improving the ability to raise complaints and concerns	**4**	**Putting families first when things go wrong** The case of Gosport has illustrated how all public agencies, within the NHS but also the police and other criminal justice agencies need to do more to ensure that when there are serious failings in care, families are properly engaged and understand what is happening. (Report June 2018; summary from Government response, November 2018).	The Government has also recently (in September 2018) published a victims' strategy, and the measures set out in this strategy will also serve to address some of the issues that have affected the Gosport families. (November 2018)	**Government response document to Gosport Report**, published November 2018 **Government Victims' Strategy** published September 2018		In December 2023, the Government published the Hillsborough Charter: Hillsborough Charter (accessible) - GOV.UK (www.gov.uk)
Ensuring care is safe.						

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From: Summary and conclusions- Report of the Gosport Independent Panel, p316 '…during the period between 1989 and 2000 at Gosport War Memorial Hospital…There was a disregard for human life and a culture of shortening the lives of a large number of patients. There was an institutionalised regime of prescribing and administering "dangerous doses" of a hazardous combination of medication not clinically indicated or justified, with patients and relatives powerless in their relationship with professional staff'. (June 2018)						
Improving patient safety	**5**	**Controlled drugs and medication safety** The management of the prescribing, dispensing, administration and monitoring of powerful drugs is a central component of patient safety. (Report June 2018; summary from Government response, November 2018).	The following key actions were suggested by the Government (November 2018): **NHS England review this year on the Controlled Drug Accountable Officer role, local reflection on the Panel Report, and on anticipatory prescribing.** **This involves the following steps:** • A review of the governance and leadership of the Controlled Drug Accountable Officer role in NHS England; • A review of the operation of the lead Controlled Drug Accountable Officers in NHS England, including the effectiveness of Local Intelligence Networks; • An assurance process to assess how 'Designated Bodies' (which include NHS Trusts and Foundation Trusts) are reflecting on the learning from the report and reviewing arrangements in their organisation in the light of it. • An assurance process focused on the appropriateness of anticipatory prescribing guidelines and that they are being followed.	**Government response document to Gosport Report**, published November 2018		In the NHS, Regional Lead Controlled Drugs Accountable Officers (CDAOs) are responsible for all aspects of Controlled Drugs management. The roles and responsibilities of CDAOs are governed by the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

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			The government also introduced a number of changes as part of its response to the Shipman Inquiry report. The Controlled Drugs (Supervision of Management and Use) Regulations 2006 (the 2006 Controlled Drugs Regulations) (as amended) mandate health care organisations to put in place standard operating procedures on the prescribing, supply and administration of controlled drugs and the clinical monitoring of patients. Tighter controls were also put in place by the Home Office through Regulations covering prescribing, record keeping and safe custody of controlled drugs. The 2006 Controlled Drugs Regulations also require the appointment of a Controlled Drug Accountable Officer.			

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Improving patient safety **Improving NHS culture and governance**	**6**	**A culture of safety – learning, staff engagement, and continuous improvement** The Panel's report shows that along with a number of unsafe practices, Gosport War Memorial Hospital also had a culture which did not create the right conditions for safe care. In part this flowed from an environment that made it difficult for staff, patients and families to question and to challenge decisions about care which were discussed in the previous chapter. The problems at Gosport also stemmed from a lack of oversight of quality and clinical governance within the hospital and the wider health system at the time. (Report June 2018; summary from Government response, November 2018).	The following key action was recommended by the government: **Continued implementation of and support for the Learning from Deaths programme, and of the commitment to put Medical Examiners in place for non-coronial deaths.** (November 2018) The government identified the following particular issues in each category and made recommendations as follows, in November 2018: Principle 6.1: Learning The Learning from Deaths programme embodies a standardised and systemic approach to examining the care provided to people who die. Trusts have each published a policy on how they respond to and learn from Deaths. Trusts are required to review and publish quarterly the numbers of death thought to be due to problems and care; and to publish evidence of learning, and preventative actions taken on an annual basis. The Care Quality Commission has strengthened its assessment of Trusts' learning from deaths as part of its annual inspections of Trusts. The Care Quality Commission's approach to inspection will include monitoring implementation of new	**Government response document to Gosport Report**, published November 2018 **NHS 'Learning from Deaths' Tool:** **NHS Guidance on working with bereaved families:** appears to have been published in July 2018 **Current NHS Patient Safety Strategy** **NHS Just Culture Guide**		The operational implementation of the medical examiner system is the responsibility of NHSE, but DHSC is the lead department for the cross-government programme of death certification reform. DHSC are working closely with NHSE the National Medical Examiner, Ministry of Justice and Government Registry Office. The intention is to put medical examiners on a statutory footing, although it has been introduced in a non-statutory capacity since 2019.

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			guidance for Trusts on working with bereaved families and carers published in July. <u>Principle 6.2: Staff engagement</u> National efforts to encourage positive changes in culture are crucial. Sign up to Safety was launched in June 2014 to strengthen patient safety in the NHS. <u>Principle 6.3: Continuous improvement</u> In addition to measurement, governance and an inquisitive / programmatic approach is required. The Patient Safety Collaborative is a joint initiative, funded and nationally co-ordinated by NHS Improvement. It identifies priorities for health improvement. <u>Principle 6.4: Further action</u> NHS Improvement has developed and published a Just Culture Guide. A new Patient Safety Strategy is to be developed and published. A new national role of NHS Chief People Officer has been created.			

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Improving patient safety	**7**	**Isolated practice** The Report identifies that the care at Gosport War Memorial Hospital was characterised by the relative isolation of the organisation of its staff who had been cut off from the norms and expectations that were in place elsewhere. (Report June 2018; summary from Government response, November 2018).	The government response in November 2018 says as follows: 'One of the lessons of the Panel's report and of a number of other reports (including the experience of a number of providers that have been through the Special Measures) is that the quality of care is in part dependent upon the strength of connections within and beyond the organisation and that poor care thrives where connections are weak. This is why the use of peer support or 'buddying' has been an important factor in helping providers in Special Measures to navigate their way back to an improved position. It is also why providers themselves, along with those inspecting and regulating them need to be alive to the potential risks of isolated practice as they do their work.'	**Government response document to Gosport Report**, published November 2018		The NHS Oversight Framework published in June 2022, replaces the quality and special measures programmes and sets out how support will be provided: B1378_NHS-System-Oversight-Framework-22-23_260722.pdf (england.nhs.uk)
Improving patient safety	**8**	**Syringe drivers** Following the publication of the report of the Panel, there were a number of media reports referring to the use of syringe drivers. These devices are used to deliver a continuous, steady dose of pain-relieving medication. When used safely they can be highly beneficial to patients. Syringe drivers were used at Gosport War Memorial Hospital, and the report mentions them on a number of occasions. As the chair of the Panel, Bishop James	The government response in November 2018 says as follows: Following the media reports, the Department of Health and Social Care has reviewed the evidence about syringe drivers, looking in particular at the patient safety alert that was issued in 2010 by the National Patient Safety Agency and subsequent action to implement it.	**Government response document to Gosport Report**, published November 2018		The Medicines and Medical Devices Act 2021 sets out key provisions regarding medical devices: Medicines and Medical Devices Act 2021 (legislation.gov.uk). The department also carried out a review of action on syringe drivers: Review of the action set

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		Jones stated in a letter to the Sunday Times after the report of the Panel was published that 'The four clinicians [on the panel] and the whole panel were unanimous that syringe drivers were not responsible for the over-prescription that led to the shortening of 456 lives'. (Report June 2018; summary from Government response, November 2018).	In the Summer, NHS Improvement undertook a survey to assess whether any of the older model of syringe drivers remained in use. While the Department's review of evidence did not establish any cause for concern about the 2010 alert or its implementation, it is undertaking further work with the NHS Improvement Patient Safety Team and the Medicines and Healthcare Products Regulatory Authority to assess what improvements could be made to ensure that safety issues linked to the design of medical devices or to the availability of safer alternatives are recognised and managed as effectively as possible.			out in 'Safer ambulatory syringe drivers' (publishing.service.gov.uk)
Identifying and addressing problems in care 'The senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) all failed to act in ways that would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved.' - Panel report, p316. (June 2018)						
Improving patient safety	**9**	**Identifying and addressing problems – inspection and improvement** The current system of inspection and provider oversight was not in place whilst the events investigated by the Gosport Independent Panel took place. The government notes there are no	The following key actions were suggested by the Government (November 2018): **CQC review of its external oversight in the light of the Panel report, including looking at responding to feedback, its assessment of medicines management (including controlled**	**Government response document to Gosport Report**, published November 2018		The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out requirements that providers must meet. They form part of the CQC's regime of

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		guarantees, but it is likely that the current system would have identified and addressed the issues at an earlier stage. (Report June 2018; summary from Government response, November 2018).	**drugs) and working with partners on prescribing issues.**			regulation and inspection of health and care providers making registration dependent on compliance with them. CQC is responsible for making sure that service providers, and other regulators, maintain a safe environment for the management and use of controlled drugs in England. CQC do this under the Controlled Drugs (Supervision of Management and Use) Regulations 2013. As part of CQC's responsibilities under these regulations, CQC report annually on what CQC find through their oversight. CQC use this information and their regulatory activities under the Health and Social Care Act 2008 to make recommendations to

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						help ensure the continuing effectiveness of the arrangements for managing controlled drugs safely in England. CQC maintain and publish an online register of controlled drugs accountable officers (CDAOs) across England. This covers those organisations that are registered with CQC and are required under the 2013 Regulations as amended to have one. The regulations define these organisations as designated bodies and require them to notify CQC of their CDAO appointment. CQC update this register monthly. At the end of 2022, there were over 1,000 CDAOs listed. CQC provide resources and helpful information for CDAOs.

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						Controlled drugs accountable officers - Care Quality Commission (cqc.org.uk)
Improving patient safety	**10**	**Working together for safety** Cases such as Gosport and Mid Staffordshire have reinforced the need for national and regional oversight bodies to work closely together to share intelligence and insight. (Report June 2018; summary from Government response, November 2018).	The following key actions were suggested by the Government (November 2018): **As NHS England and NHS Improvement work more closely together, they are putting joint oversight of the quality of care at the heart of their new structures.** NHS Improvement, working with other national organisation, plans to run regional exercises to stress test the approach to oversight. The purpose of these exercises will be to consider the following questions: a. What should we collectively have spotted earlier, and what would need to change to make sure that we do next time? b. What additional information or intelligence would make it more likely that concerns are identified early in future?	**Government response document to Gosport Report**, published November 2018		The NHS oversight framework replaces the NHS system oversight framework for 2021/22, which described NHS England's approach to oversight of integrated care boards (ICBs) and trusts.

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Improving patient safety	**11**	**Identifying and addressing problems - professional regulation** The system of professional regulation has changed significantly since the events described in the Panel report. Professional regulation has been reformed to make it more independent from both the professionals they regulate and from Government. (Report June 2018; summary from Government response, November 2018).	The following key actions were suggested by the Government (November 2018): **Government commitment to bring forward proposals to reform the framework for professional regulation.** The Government recognises in its response that the current framework for regulation is insufficient, following a consultation in 2017-2018 conducted by all four United Kingdom governments. In addition to this work to reform the system of professional regulation as a whole, the regulators themselves have been reflecting on the Panel's report to assess the lessons to be learned and how other reforms in recent years have added to the system's resilience.	**Government response document to Gosport Report**, published November 2018		The changes set out in the Williams Review ("Gross negligence manslaughter in healthcare The report of a rapid policy review", June 2018), are designed to improve the system by encouraging healthcare professionals to reflect on their practice. In 2021, the government consulted on proposals to reform the legislation of all healthcare professional regulators including GMC and NMC. The proposed changes will provide all professional regulators with broadly consistent powers to carry out their functions of: registration, fitness to practise, education and training, governance. The consultation response was published in February 2023 and sets out the policy approach for future reform.

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Improving the ability to raise complaints and concerns	**12**	**General Medical Council** The General Medical Council's primary purpose is to protect patients. Chapter 6 shows that concerns about the hospital were brought to the attention of the General Medical Council in 2000. It also describes the circumstances that meant there was a ten-year delay before the General Medical Council's Fitness to Practise Panel considered sanctions against Dr Jane Barton, clinical assistant at the hospital. (Gosport Report, June 2018). There have been a number of changes to the General Medical Council since the events of the report, set out to the right. (Summary from Government response, November 2018).	The following key actions were suggested by the Government (November 2018): **The General Medical Council commitments to introduce a senior patient champion; and to review the relationship between its processes and those of the police.** The government response document also sets out a number of changes that have been made to the General Medical Council in recent years and since the events investigated by the Panel, including a reduction of members in the General Medical Council's council which registers and regulates doctors; establishment of the Medical Practitioners Tribunal Service; an ongoing system of revalidation of doctors in December 2012 with annual appraisals; and introduction of the Patient Liaison Service.	**Government response document to Gosport Report**, published November 2018		In 2021, the government consulted on proposals to reform the legislation of all healthcare professional regulators including GMC and NMC. The proposed changes will provide all professional regulators with broadly consistent powers to carry out their functions of: registration, fitness to practise, education and training, governance. The consultation response was published in February 2023 and sets out the policy approach for future reform. It includes more information on the timing and sequencing of these reforms, which, from 2024, will see physician and anaesthesia associates brought under the regulation of GMC under the new framework.

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Improving patient safety	**13**	**Nursing and Midwifery Council** The Nursing and Midwifery Council's main objective is to safeguard the health and well-being of people using or needing the services of its registrants. Chapter 7 demonstrates a similar pattern with the Nursing and Midwifery Council as the statutory regulator for nurses. From the point of referral to its predecessor body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, in 2000, it would take ten years for the Preliminary Proceedings Committee to decline to proceed in respect of all the allegations against the nurses concerned. (Gosport Report, June 2018).	The following key actions were suggested by the Government (November 2018): **In light of the Panel report, the Nursing and Midwifery Council has made commitments to accelerate the introduction of its Public Support Service; and work with nurses to identify the key learning from the Panel report for the profession.** It is noted again by the government that the Nursing and Midwifery Council has changed significantly since the events described in the Panel report, including issuing of a new Code, a new system of nurse revalidation, and additional guidance.	**Government response document to Gosport Report**, published November 2018		In 2021, the government consulted on proposals to reform the legislation of all healthcare professional regulators including GMC and NMC. The proposed changes will provide all professional regulators with broadly consistent powers to carry out their functions of: registration, fitness to practise, education and training, governance. The consultation response was published in February 2023 and sets out the policy approach for future reform.
Improving patient safety	**14**	**General Pharmaceutical Council** Did not exist at the time of the Panel report but is now a relevant body.	The following key actions were suggested by the Government (November 2018): **The General Pharmaceutical Council has made a commitment to work with the pharmacy representative bodies to develop a framework for pharmacy to assess what changes have already been made to help**	**Government response document to Gosport Report**, published November 2018		"Managing concerns about pharmacy professionals Our strategy for change 2021-26", published in July 2021, sets out the General Pharmaceutical Council's strategy for

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			prevent a similar situation to that described in the Panel report happening again and encourage discussion across pharmacy on any further actions that could be taken.			pharmacy professionals, taking account of the Gosport Independent Panel's work and other reviews and reports. Managing concerns about pharmacy professionals (pharmacyregulation.org)
Improving patient safety	**15**	**Medical Examiners** One of the critical failings identified by the Panel's report was the failure of the hospital or the wider NHS to look at individual deaths or patterns of deaths to see whether there was learning, improvement or intervention required in response. (Report June 2018; summary from Government response, November 2018).	The following key actions were suggested by the Government (November 2018): **Appointment of a National Medical Examiner to provide professional and strategic leadership and set quality standards for Medical Examiners.** This is in addition to the work on Learning from Deaths which is set out in relation to above principles and issues.	**Government response document to Gosport Report**, published November 2018		The operational implementation of the medical examiner system is the responsibility of NHSE, but DHSC is the lead department for the cross-government programme of death certification reform. DHSC are working closely with NHSE, the National Medical Examiner, Ministry of Justice and Government Registry Office. The intention is to put medical examiners on a statutory footing, although it has been introduced in a non-statutory capacity since 2019, already establishing all 126

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						medical examiner offices hosted by NHS acute trusts.
Improving the ability to raise complaints and concerns	**16**	**Healthcare Investigations** The case of Gosport, along with a number of other failings in care in recent years have highlighted the need for improved healthcare investigations in the interest of organisational and system learning. (Report June 2018; summary from Government response, November 2018).	The following key actions were suggested by the Government (November 2018): **Revision of the NHS Serious Incident Framework.** The Serious Incident Framework is now being replaced with the Patient Safety Incident Response Framework (published 14 September 2022). The Government also established the Healthcare Safety Investigation Branch in 2016 which conducts investigations into patient safety incidents. The case of Gosport has also reinforced the importance of listening to the concerns of patients and their families. The Department of Health and Social Care is considering its policy regarding historical unresolved cases in the NHS so that we can ensure that patients and families have the right platform to have their voices heard.	**Government response document to Gosport Report**, published November 2018 **Patient Safety Incident Response Framework**: Updated 14 September 2022		In October 2023, we set up the Health Service Safety Investigations Body as a new independent executive non-departmental public body, to get to the root cause of patient safety incidents within our health service and to embed system-wide learning.

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Improving the ability to raise complaints and concerns	**17**	**Police investigations, criminal justice processes, Inquests and coronial processes** While the Panel report helps us to understand the distinct rationales for the different investigations, it is also clear that the cumulative effect from the perspective of the families was of a confusing, overlapping, under-co-ordinated and, for them, ultimately unsatisfactory set of investigations and assessments of the evidence. The different agencies did not always work well together and, while it is clearly important for each to operate faithfully within their own statutory remit, the consequences for the families were often difficult for them to understand or accept. (Report June 2018; summary from Government response, November 2018).	The following key actions were suggested by the Government (November 2018): **The Government will explore what more can be done to ensure that investigatory processes relating to serious concerns (whether on an organisational or individual level) relating to healthcare are organised so that they both are fully compliant with the relevant statutory remits and the interests of justice while also recognising and addressing the concerns and priorities of patients and their families.** **The Ministry of Justice will refresh its Guide to Coroner Services to make it better tailored to the needs of bereaved families.** **The Government has committed to establish an Independent Public Advocate and published its consultation on the role on 10 September 2018.** The Chief Constable of Hampshire Police also responded to the report accepting the findings and acknowledging failures on behalf of the force.	**Government response document to Gosport Report**, published November 2018		The NHS England » Patient Safety Incident Response Framework and supporting guidance rolled out from August 2022, includes guidance on engaging and involving patients and families following a patient safety incident. In January 2020, the Ministry of Justice published the refreshed Guide to coroner services to help bereaved people understand the inquest process, their rights and responsibilities, and what they can do if they feel these are not being met. The guide includes information about where the bereaved can find emotional and practical support – not just with the inquest process but also to cope with bereavement.

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						In December 2023, the Government announced the Independent Panel Advocate (IPA), to support survivors and bereaved families of major disasters. Trained advocates will provide practical support to families, the bereaved and those who have suffered life-changing injuries including signposting them to vital financial, physical and mental health services such as Victim Support, the Homicide Service and any charities established as a result of a major disaster.

24 KARK REVIEW OF THE FIT AND PROPER PERSONS TEST

24.1 Introduction

An independent review commissioned by the Minister of State for Health in July 2018, in relation to the Fit and Proper Person Test under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as it applies to directors.

The review was conducted and chaired by Tom Kark KC.

The report of the Kark Review was delivered to the Government in November 2018, and published in February 2019. The report can be viewed online.

An examination of the Fit and Proper Person Test was recommended by Dr Bill Kirkup in the Report of the Liverpool Community Health Independent Review. The Kark Review was commissioned to report on the effectiveness of the Fit and Proper Person Test as it applied to directors within the health service in England and make recommendations in relation to the operation of the test.

24.2 Kark Review of the Fit and Proper Person Test: Table of Recommendations

Kark Review of the Fit and Proper Person Test						
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**	**DHSC Comments**
Regulation and oversight of NHS managers	**1**	**All directors should meet specific standards of competence to sit on the board of any health providing organisation. Where necessary, training should be available.** NHS Improvement, in consultation with other bodies, should design and set higher level core competencies. These should be embodied in a schedule to the Regulations, with further guidance provided as appropriate. Trusts should ensure any necessary training is undertaken by board members where gaps in competency are identified. During the Care Quality Commission 'Well-Led' inspections, the Care Quality Commission should review evidence to ensure directors are currently able to meet core competencies, have regular appraisals and are up to date with personal development plans. This approach should be kept under review with consideration to be given as to whether a formalised gateway,	Secretary of State for Health and Social Care accepted recommendation. NHS England published the Fit and Proper Person Test Framework in August 2023, effective from 30 September 2023 and applicable to board members of NHS organisations. The Fit and Proper Person Test Framework is designed to assess the appropriateness of an individual to effectively discharge their duties in the capacity of a board member. The Fit and Proper Person Test Framework refers to the new NHS Leadership Competency Framework (not yet published) as providing guidance for the competence categories against which a board member should be appointed, developed and appraised. A new board appraisal framework will also be published, incorporating the Leadership Competency Framework, by March 2024. The Leadership Competency Framework will help inform the 'fitness' assessment in Fit and Proper Person Test Framework. This is in line with the	NHS England, 'Appendix 1: Recommendations from the Kark Review (2019)' (NHS England, 2 August, 2023) NHS England, 'NHS England Fit and Proper Person Test Framework for board members' (27 September 2023) NHS England, 'NHS managers and leaders'		We understand NHSE intend to implement this recommendation without amendments to the FPP Regulation.

Kark Review of the Fit and Proper Person Test						
		registration and validation system is necessary. Recommended amendment: *"Consideration should be given to the following amendments to the FPP Regulation:* *That in order to give effect to Recommendation 1, a new schedule to the Regulations is created listing required competencies for Board directors and their equivalents, and that a new subparagraph is inserted into Regulation 5 of the Regulations to require consideration of the schedule when assessing whether an individual is compliant with 5 (3)(b) of the Regulations."* (November 2018)	Kark Review's (2019) recommendations on professional standards. Unable to find evidence of amendment to the Regulations.			
Regulation and oversight of NHS managers	**2**	**That a central database of directors should be created holding relevant information about qualifications and history.** A central database of directors should be created holding relevant information about qualifications and history, accessible to potential employers, NHS	Secretary of State for Health and Social Care accepted recommendation. NHS England published the Fit and Proper Person Test Framework in August 2023, effective from 30 September 2023 and applicable to board members of NHS organisations.	NHS England, 'Appendix 1: Recommendations from the Kark Review (2019)' (NHS England, 2 August, 2023)		

Kark Review of the Fit and Proper Person Test						
		Improvement and the Care Quality Commission. Employers should be required within a reasonable time to provide the specified information in relation to each person identified as a director and Trusts should keep that information regularly updated and current. The Care Quality Commission should review whether or not Trusts have complied with the duty during their 'Well-Led' inspections. (November 2018)	The Fit and Proper Person Test Framework (August 2023) refers to the hosting of an Electronic Staff Record by NHS Business Services Authority, which will hold individual Fit and Proper Person Test Framework information for all board members. Fit and Proper Person Test Framework information will include references and should be reviewed annually by the relevant NHS organisation to ensure it remains up to date.	NHS England, 'NHS England Fit and Proper Person Test Framework for board members' (27 September, 2023)		
Regulation and oversight of NHS managers	**3**	**The creation of a mandatory reference requirement for each Director** Full, honest and accurate mandatory employment references for each director should be required. Such references must not be subject to any limitation by the terms of a compromise or settlement agreement; any such attempted limitation should be regarded as of no effect. The old employer must provide such a reference and the new employer must require one. Where an applicant is being promoted from a non-board director position or is moving from a directorship role not covered by the Regulations, the new employer must make every reasonable attempt to obtain a reference	Secretary of State for Health and Social Care accepted recommendation. The Fit and Proper Person Test Framework (August 2023) refers to the introduction of a standardised board member reference with board member references to apply as part of the Fit and Proper Person Test Framework assessment where there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS or external to the NHS. This does not appear to implement the elements of Recommendation 3 relating to settlement/confidentiality agreements, in that the Fit and Proper Person Test Framework states where such an agreement is in place,	NHS England, 'NHS England Fit and Proper Person Test Framework for board members' (27 September, 2023) NHS England, 'Appendix 1: Recommendations from the Kark Review (2019)' (NHS England, 2 August, 2023)		We understand NHSE intend to implement this recommendation without amendments to the FPP Regulation.

Kark Review of the Fit and Proper Person Test						
		meeting the requirements of the mandatory reference and acquire any missing information. Each mandatory reference form written for an ongoing director should be signed by a board director. References should be retained and supplied to the central database. The Care Quality Commission should review employment references provided by Trusts as part of their 'Well-Led' review. Recommended amendment: "*That in order to give effect to Recommendation 3, that Schedule 3 of the Regulations be amended so as to incorporate reference to the mandatory reference form*." (November 2018)	NHS organisations should seek permission for all parties before including such information in a reference. Nor has statutory amendments to the Regulations been made.			
Regulation and oversight of NHS managers	**4**	**"The Fit and Proper Person Test Framework should be extended to all Commissioners and other appropriate Arms-Length Bodies (including NHS Improvement and NHS England)."** The Fit and Proper Person Test Framework should be extended to all commissioners and other appropriate Arms-Length Bodies (including NHS Improvement and NHS England) A	Secretary of State for Health and Social Care accepted recommendation. Integrated care boards, together with the Care Quality Commission and NHS England, are within scope of the Fit and Proper Person Test Framework (August 2023).	NHS England, 'Appendix 1: Recommendations from the Kark Review (2019)' (NHS England, 2 August, 2023) NHS England, 'NHS England Fit and Proper Person		

Kark Review of the Fit and Proper Person Test						
		scoping exercise should be undertaken with a view to the test being extended by statute to be so extended. (November 2018)	Applies to NHS trusts, foundation trusts, integrated care boards, the Care Quality Commission and NHS England.	Test Framework for board members' (27 September, 2023)		
Regulation and oversight of NHS managers	**5**	**"The power to disbar directors for serious misconduct".** An organisation should be set up with the power to suspend and disbar directors found to have committed serious misconduct. Such an organisation could be housed within NHS Improvement and known as the Health Directors' Standards Council. Employment contractors for board-level directors should reflect that a finding of serious misconduct is to be regarded as gross misconduct for the purposes of employment. The Care Quality Commission and all appropriate arms-length bodies should amend their appointment rules to prevent them employing someone disbarred for serious misconduct. All NHS commissioners should be prohibited from commissioning services where a disbarred or suspended director sits on the board on the provider. (Consideration should be given to the following amendments to the Fit and Proper Person Regulations: That in order	Secretary of State for Health and Social Care did not accept recommendation. However – this is possibly being revisited in light of the Lucy Letby trial. (see Hansard below - 4 September 2023). *"the NHS actively considered Kark's recommendation 5 on disbarring senior managers and took the view that introducing the wider changes he recommended in his review mitigated the need to accept that specific recommendation on disbarring. The point was considered further by the Messenger review." (col 37)* *"We must act to prevent further tragedies, so I welcome the Secretary of State's announcement that his Department is reconsidering Kark's recommendation 5." (col 39)*	NHS England, 'Appendix 1: Recommendations from the Kark Review (2019)' (NHS England, 2 August, 2023) **Hansard** HC Deb 4 September 2023, vol 737, cols 37-39		The Government is currently exploring whether further mechanisms are needed to hold NHS managers accountable, including the possibility of a disbarring system. This will be considered alongside the actions recommended by General Sir Gordon Messenger's review of leadership published in June 2022. Petition response Create a new regulatory body to hold NHS managers accountable - Petitions (parliament.uk)

Kark Review of the Fit and Proper Person Test						
		to give effect to Recommendation 5, that Part 1 of Schedule 4 of the Regulations be amended to include anyone disbarred or suspended by the Health Directors' Standards Council. That in order to ensure that the test of Serious Misconduct as defined for the purposes of the Health Directors' Standards Council is consistent with the Fit and Proper Person Regulations. Regulation 5 (3) (d) of the Regulations be amended so as to require consideration of the same issues as described in Recommendation 5.2 (13.5.2) above.) (November 2018)				
	6	**"In relation to Regulation 5 (3) (d) of the Regulations, the words "been privy to" are removed."** (November 2018)	Secretary of State for Health and Social Care accepted recommendation, but this has not yet been implemented.	NHS England, 'Appendix 1: Recommendations from the Kark Review (2019)' (NHS England, 2 August, 2023)		
Improving patient safety	**7**	**"We recommend that further work is done to examine how the test works in the context of the provision of social**	Secretary of State for Health and Social Care did not accept recommendation.	NHS England, 'Appendix 1: Recommendations from the Kark Review (2019)'		

Kark Review of the Fit and Proper Person Test						
		care and whether any amendments are needed to make the test effective." (November 2018)		(NHS England, 2 August, 2023)		

25 CWM TAF INQUIRY

25.1 Introduction

Following concerns with the under-reporting of serious-incident cases by the maternity service, the Royal College of Obstetrics and Gynaecology was commissioned by the Welsh Government to undertake an external review to investigate the care provided by the maternity services of Cwm Taf University Health Board, specifically the Prince Charles Hospital and Royal Glamorgan Hospital.

Royal College of Obstetrics and Gynaecology reviewed the period between 1 Jan 2016 to November 2018 and published their report on 30 April 2019. The assessors found a service working under extreme pressure and under sub-optimal clinical managerial leadership. The link to the report is here.

Following publication of the review, the Minister for Health and Social Services announced that he was placing maternity services in the former Cwm Taf University Health Board into 'special measures'. The Minister appointed an independent panel, the Independent Maternity Services Oversight Panel ("**the Panel**"), to provide the oversight which is necessary to ensure that Cwm Taf Morgannwg University Health Board addresses the failings identified by the Royal Colleges' in a timely, open and transparent manner.

In November 2019, as a result of Royal Colleges' report, Healthcare Inspectorate Wales and Audit Wales undertook a joint review of quality governance and risk management arrangements within the Health Board. The link to the report is found here.

In March 2021, the Panel made a recommendation to the then Minister of Health that there should be an increased focus on neonatal services within the oversight process. The Minister accepted this recommendation and authorised a neonatal 'deep-dive' exercise to assess the quality and safety of the neonatal services being provided by the Health Board at **Prince Charles Hospital** specifically. The link to the report is found here.

In its September 2021 progress report, the Panel determined that the recommendations from the review by the Royal College of Obstetrics and Gynaecology were no longer suitable to track progress but would be included in a form of long-term plan.

As explained by the Panel in its September 2022 progress report (link):

"In May 2022, the Panel made a recommendation to the Minister that the Royal Colleges' action plan should be discharged and that the outstanding elements should be scheduled for delivery within the Health Board's longer-term Maternity and Neonatal Improvement Plan. That proposal was supported by the Minister and as such, the Royal Colleges' action plan has now been closed by the Health Board. Over the last six months, the Panel has regularly reviewed changes in the Maternity and Neonatal Improvement Plan and is satisfied that all of the outstanding elements of the Royal Colleges' recommendations have been systematically transitioned across and scheduled for delivery in future with clear timelines and accountabilities."

Therefore, the recommendations from the original report by the Royal College of Obstetrics and Gynaecology (April 2019), the joint review by Healthcare Inspectorate Wales and Audit Wales (November 2019) and the "deep dive" review by the Panel into the Prince Charles Hospital has been reviewed below.

25.2 Cwm Taf Inquiry: Table of Recommendations

(a) Royal College of Obstetricians and Gynaecologists: Review of Maternity Services at Cwm Taf Health Board (April 2019)

Cwm Taf Inquiry: RCOG Review					
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
TOR 1: To review the current provision of care within maternity services in relation to national standards and indicators, as well as national reporting.					
Improving NHS culture and governance	**1**	Urgently review the systems in place for: • data collection, • clinical validation, • checking the accuracy of data used to monitor clinical practice and outcomes, • what information is supplied to national audits. *(April 2019)*	Panel deems that evidence provided meets recommendation requirements. (p. 37) *(April 2022)*	Independent Maternity Services Oversight Panel, Progress Report April 2022	
Improving NHS culture and governance	**2**	Identify nominated individuals (consultant obstetric lead and senior midwife) to ensure that all maternity unit guidelines: • are up to date and regularly reviewed, • are readily available to all staff, including locum staff and midwifery staff, • have a multi-disciplinary approach, • are adhered to in practice. *(April 2019)*	Panel verified as complete 3.8.2020. Verification based on assessment of documentary evidence and probing conversations. (p. 29)	Independent Maternity Services Oversight Panel, Progress Report September 2020	
Improving NHS culture and governance	**3**	Mandate and support a full programme of clinically led audit with a nominated consultant lead to measure performance and outcomes against guidelines. *(April 2019)*	Panel agreed as complete at 16.12.19. Lead nominated May 2019. Audit Plan agreed via Governance structure. Audit plan monitored via the Audit and Research Forum. (p.46)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	

Cwm Taf Inquiry: RCOG Review					
Improving NHS culture and governance	**4**	Ensure monitoring of clinical practice of all staff is undertaken by the Clinical Director and Head of Midwifery: • to ensure compliance with guidelines, • to ensure competency and consistency of performance is included in annual appraisal. *(April 2019)*	Panel agreed as complete at 16.12.19. Personal Development Reviews in place for all staff. Clinical reflection sessions embedded into all of the units. (p.46)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	
Improving patient safety	**5**	Agree a CTG training programme that includes a competency assessment which is delivered to all staff involved in the care of pregnant women, both in the antenatal period and intrapartum. *(April 2019)*	Reviewed in 2021, and followed up in April 2022 to ensure improvements are being embedded in practice. (September 2021) (p. 41) Panel deems evidence provided meets recommendation requirements. Training compliance will be demonstrated in the outstanding element of recommendation 35. *(April 2022)* (p. 41)	Independent Maternity Services Oversight Panel, Progress Report September 2021 Independent Maternity Services Oversight Panel, Progress Report April 2022	
Improving NHS culture and governance	**6**	Obstetrics and gynaecology consultant staff must deliver: • standard induction programme for all new junior medical staff • a standard induction programme for all locum doctors. *(April 2019)*	Panel agreed as complete 6.12.19 and re-verified at 18.02.20. (p.75)	Independent Maternity Services Oversight Panel, Progress Report Spring 2020	
	7	Ensure an environment of privacy and dignity for women undergoing abortion or miscarriage in line with agreed national standards of care. *(April 2019)*	A Gynaecology Day Assessment Unit pathway and standard operating model have been developed and signed off by the executive team. Suitable facilities have been	Independent Maternity Services	

Cwm Taf Inquiry: RCOG Review					
			commissioned and the Gynaecology Day Assessment Unit service has 'gone live'. (September 2022) (p. 37)	Oversight Panel, Progress Report September 2022	
TOR 2: Assess the prevalence and effectiveness of a patient safety culture within maternity services including the understanding of staff of their roles and responsibilities for delivery of that culture; identifying any concerns that may prevent staff raising patient safety concerns within the Trust; assessing that services are well led and the culture supports learning and improvement following incidents;					
Improving patient safety	**8**	Ensure external expert facilitation to allow a full review of working practice to ensure: • patient safety is considered at all stages of service delivery, • a full review of roles and responsibilities within the obstetric team, • the development and implementation of guidelines, • an appropriately trained and supported system for clinical leadership, • a long term plan and strategy for the service, • there is a programme of cultural development to allow true multi-disciplinary working. *(April 2019)*	Panel closed recommendation in April 2022. Evidence previously provided meets the requirement for some elements of this recommendation. However, the remaining aspects overlap with the strategy development work (number 67) and duplicated. (p. 37)	Independent Maternity Services Oversight Panel, Progress Report April 2022	
Improving patient safety	**9**	Develop a trigger list for situations which require consultant presence on the labour ward 3 which must be: • agreed by all consultants in obstetrics, paediatrics and anaesthetics and senior midwives, • audited and reported on the maternity dashboard.	Panel agreed as complete at 16.12.19. E.g. Trigger list developed and embedded within the maternity information technology system. - Datix data reported via the dashboard to monitor reporting rates. (p.46)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	

Cwm Taf Inquiry: RCOG Review					
		(April 2019)			
Improving patient safety **Improving NHS culture and governance**	**10**	Introduce regular risk management meetings which must be: • open to all staff, • conducted in an open and transparent way, • held at a time and place to allow for maximum attendance. *(April 2019)*	Panel agreed as complete at 16.12.19, with 6 month follow up to ensure embedded. Weekly incident review meeting established. The dedicated foetal surveillance Midwife, monitors DATIX reporting of any patients that fall in the Growth Assessment Protocol (GAP). Any concerns that are identified are fed in the weekly incident review meeting. (p.47)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	
Improving NHS culture and governance	**11**	Ensure mandatory attendance at the following meetings for all appropriate staff. Attendance must be recorded and included in staff appraisals. Ensure that meetings are to be scheduled or elective clinical activity modified to allow attendance at: • governance meetings, • audit meetings, • perinatal mortality meetings. *(April 2019)*	Panel agreed as complete 6.12.19 and re-verified at 18.02.20. (p.74)	Independent Maternity Services Oversight Panel, Progress Report Spring 2020	
Improving patient safety **Improving the ability to raise complaints**	**12**	Undertake multidisciplinary debriefing sessions facilitated by senior maternity staff after an unexpected outcome. *(April 2019)*	Panel agreed as complete at 16.12.19. Multi-disciplinary team de-briefing process now in place. (p.47)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	
Improving NHS culture and governance	**13**	Identify a clinical lead for governance from within the consultant body. This individual must: • be accountable for good governance, • attend governance meetings to ensure leadership and engagement.	Panel agreed as complete 18.02.20. (p. 75)	Independent Maternity Services Oversight Panel, Progress Report Spring 2020	

Cwm Taf Inquiry: RCOG Review					
		(April 2019)			
Improving NHS culture and governance	**14**	Consultant meetings should: • be regular in frequency, • have a standing agenda item on governance, • be joint meetings with anaesthetic and paediatric colleagues. *(April 2019)*	Panel agreed as complete 6.12.19, and re-verified at 18.02.20. (p. 75)	Independent Maternity Services Oversight Panel, Progress Report Spring 2020	
Improving the ability to raise complaints	**15**	Educate all staff on the accountability and importance of risk management, Datix reporting and review and escalating concerns in a timely manner. Include this at: • junior doctor induction, • locum staff induction, • midwifery staff induction, • annual mandatory training. *(April 2019)*	Panel verified as complete 3.8.2020. Verification based on assessment of documentary evidence and probing conversations. (p. 30)	Independent Maternity Services Oversight Panel, Progress Report September 2020	
Improving NHS culture and governance **Improving patient safety**	**16**	Urgent steps must be taken to ensure that consultant obstetricians are immediately available when on call (maximum 30 minutes from call to being present). *(April 2019)*	Panel agreed as complete 16.12.19, and re-verified at 23.03.20. (p. 74)	Independent Maternity Services Oversight Panel, Progress Report Spring 2020	
Improving NHS culture and governance	**17**	Ensure training is provided for all specialty and associate specialist staff to ensure that they are: • up to date with clinical competencies, • skilled in covering high risk antenatal clinics and out-patient sessions. *(April 2019)*	Panel: Evidence provided meets recommendation requirements. (p. 37) *(April 2022)*	Independent Maternity Services Oversight Panel, Progress Report April 2022	

Cwm Taf Inquiry: RCOG Review					
Improving NHS culture and governance	**18**	Agree cohesive methods of consultant working after the merger with input from anaesthetic and paediatric colleagues. *(April 2019)*	Reviewed in 2021, and followed up in April 2022 to ensure improvements are being embedded in practice. (September 2021) (p. 41) Panel deems evidence provided meets recommendation requirements. *(April 2022) (p. 41)*	Independent Maternity Services Oversight Panel, Progress Report September 2021 Independent Maternity Services Oversight Panel, Progress Report April 2022	
ToR 3: Review the root cause analysis investigation process, how serious incidents are identified, reported and investigated with the maternity services; how recommendations from investigations are acted upon by the maternity services; how processes ensure sharing of learning amongst clinical staff, senior management and stakeholders and whether there is clear evidence that learning is undertaken and embedded as a result of any incident or event. **Work is required to address the culture in relation to governance and supporting all staff with their accountability in relation to incident reporting, escalation of concerns and review of Datix in a timely manner.**					
Improving patient safety	**19**	Ensure that a system for the identification, grading and investigation of serious incidents is embedded in practice, through: • appropriate training to key staff members, • making investigations multidisciplinary and including external assessors. *(April 2019)*	Panel closed - note external neonatology input into serious incident investigations is still in its infancy however this will be picked up in response to the neonatal deep-dive escalation immediate action 7 (see below). (p. 38) *(April 2022)*	Independent Maternity Services Oversight Panel, Progress Report April 2022	
Improving the ability to raise complaints	**20**	Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from serious incidents. *(April 2019)*	Panel closed - Evidence provided meets recommendation requirements.	Independent Maternity Services Oversight Panel, Progress Report April 2022	

Cwm Taf Inquiry: RCOG Review					
Improving NHS culture and governance	**21**	Improve incident reporting by: • delivering training on the use of the Datix system for all staff, • encouraging the use of the Datix system to record clinical incidents, • monitor the usage of the incident reporting system. *(April 2019)*	Panel verified as complete 3.8.2020. Verification based on assessment of documentary evidence and probing conversations. (p. 29)	Independent Maternity Services Oversight Panel, Progress Report September 2020	
Improving NHS culture and governance	**22**	Actively discuss the outcomes of serious incidents in which individual consultants were involved in their appraisal. *(April 2019)*	Reviewed in 2021, and followed up in April 2022 to ensure improvements are being embedded in practice. (September 2021) (p. 41) Panel deems evidence provided meets recommendation requirements. *(April 2022) (p. 41)*	Independent Maternity Services Oversight Panel, Progress Report September 2021 Independent Maternity Services Oversight Panel, Progress Report April 2022	
Improving NHS culture and governance	**23**	Improve learning from incidents by sharing the outcomes from serious incidents on a regular basis and in an appropriate, regular and accessible format. *(April 2019)*	Reviewed in 2021, and followed up in April 2022 to ensure improvements are being embedded in practice. (September 2021) (p. 41) Panel deems evidence provided meets recommendation requirements. *(April 2022) (p. 41)*	Independent Maternity Services Oversight Panel, Progress Report September 2021 Independent Maternity Services Oversight Panel, Progress Report April 2022	

Cwm Taf Inquiry: RCOG Review					
Improving NHS culture and governance	**24**	Identify a clinical lead from senior medical staff within the directorate to support the current midwifery governance lead. *(April 2019)*	Panel agreed as complete at 18.02.20. (p.75)	Independent Maternity Services Oversight Panel, Progress Report Spring 2020	
ToR 4: Review how through the governance framework the Health Board gains assurance of the quality and safety of maternity and neonatal services.					
Improving NHS culture and governance	**25**	Appoint a consultant and midwifery lead for clinical audit/quality improvement with sufficient time and support to fulfil the role to ensure: • that clinical audits are multidisciplinary, • that there is a clinically validated system for data collection, • that the lead encourages all medical staff to complete an audit/quality improvement project each year to form part of their annual appraisal dataset, • sharing of the outcomes of clinical audits and the performance against national standards. *(April 2019)*	Panel re-verified as complete 12.8.2020. Verification based on assessment of documentary evidence and probing conversations. (p. 29)	Independent Maternity Services Oversight Panel, Progress Report September 2020	
Improving NHS culture and governance	**26**	Agree jointly owned neonatal and maternity services audits of neonatal service data including • neonatal outcome data, • perinatal deaths, • transfer of term babies to Special Care Baby Unit, • babies sent for cooling, • Each Baby Counts reporting, • MBRRACE reporting, • breast feeding rates,	Panel agreed as complete at 16.12.19, with 6 month follow up to ensure embedded. Forums in place and monitor audit performance. (p.49)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	

Cwm Taf Inquiry: RCOG Review					
		• skin to skin care after birth, • neonatal infection, • Baby Friendly accreditation • Bliss baby charter accreditation. *(April 2019)*			
Improving NHS culture and governance	**27**	Consider extra resource to the Maternity Governance and Risk team to ensure: • workload is manageable, • that Datix are reviewed, graded and actioned in an appropriate and timely manner. *(April 2019)*	Reviewed in 2021, and followed up in April 2022 to ensure improvements are being embedded in practice. (September 2021) (p. 41) Closed with some outstanding elements: Improvement programme plans need to include a review of resourcing in six months' time.*(April 2022) (p. 41)* In September 2022, the Panel confirmed evidence showed this had been delivered.	Independent Maternity Services Oversight Panel, Progress Report September 2021 Independent Maternity Services Oversight Panel, Progress Report April 2022	
Improving NHS culture and governance **Improving patient safety**	**28**	Ensure that the executive level lead role for maternity will work with the maternity department and this role is effective and supported. This individual should • have a direct progress reporting responsibility to the Board, in particular while the issues raised in this report are being resolved • understand and facilitate improvement in the reporting of safety issues and clinical risk, • provide a single point of reference for liaison with external agencies, • ensure all reports from external agencies and regulators are channelled through a single pathway to ensure priorities remain focussed.	Panel agreed as complete at 16.12.19. There is dedicated executive lead role for maternity in place who is also the Senior Responsible Owner for the Maternity Improvement Programme. This lead conducts regular ward walk-arounds and escalates any findings of concern directly to the senior leadership and/or to Board via governance arrangements. (p.53)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	

Cwm Taf Inquiry: RCOG Review					
		(April 2019)			
ToR 5: Review the current midwife and obstetric workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.					
Improving NHS culture and governance	**29**	Closely monitor bank hours undertaken by midwives employed by Cwm Taf, to ensure: • the total number of hours is not excessive, • the Health Board complies with the European Working Time Directive, • these do not compromise safety. *(April 2019)*	Panel re-verified as complete 3.8.2020. Verification based on assessment of documentary evidence and probing conversations. (p. 30)	Independent Maternity Services Oversight Panel, Progress Report September 2020	
Improving patient safety	**30**	Ensure the Medical Director has effective oversight and management of the consultant body by: • making sure they are available and responsive to the needs of the service, • urgently reviewing and agreeing job plans to ensure the service needs are met, • clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, data assurance, train more consultant obstetricians as appraisers), • ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12 hour National	Reviewed in 2021, and followed up in April 2022 to ensure improvements are being embedded in practice. (September 2021) (p. 41) Closed with some outstanding elements: Improvement programme plans need to include an audit in six months' time to assess the average and range of time taken for emergency admissions to be reviewed at consultant level. (April 2022) (p. 42)	Independent Maternity Services Oversight Panel, Progress Report September 2021 Independent Maternity Services Oversight Panel, Progress Report April 2022	

Cwm Taf Inquiry: RCOG Review					
		Confidential Enquiry into Patient Outcome and Death recommendation (national standard). *(April 2019)*			
Improving NHS culture and governance	**31**	Ensure a robust plan of births anticipated in each midwifery led unit and consultant led unit is undertaken, • ensure involvement of paediatric staff for all future service design reviews and actions. *(April 2019)*	Panel closed with some outstanding elements: Strategy development needs to include long term demographic planning and demand modelling for future births. This should be jointly completed by the maternity and neonatal services based on agreed strategic service change principles. (April 2022) (p. 38)	Independent Maternity Services Oversight Panel, Progress Report April 2022	
Improving NHS culture and governance	**32**	Ensure obstetric consultant cover is achieved in all clinical areas when required by: • reviewing the clinical timetables to ensure that 12 hour cover per day on labour ward is achieved, • undertake a series of visits to units where extended consultant labour ward presence has been implemented. • considering working in teams to ensure a senior member of the team is available in clinics and provide cross cover for each other, • considering the creative use of consultant time in regular hours and out of hours to limit the use of locums. *(April 2019)*	Reviewed in 2021, and followed up in April 2022 to ensure improvements are being embedded in practice. (September 2021) (p. 41) Panel closed: Evidence provided meets recommendation requirements.	Independent Maternity Services Oversight Panel, Progress Report September 2021 Independent Maternity Services Oversight Panel, Progress Report April 2022	
	33	Actively share the findings of this Royal College of Obstetricians and Gynaecologists review with the Welsh Deanery and urgently encourage them to revisit the Health Board to:	Panel agreed as complete at 18.02.20. (p.76)	Independent Maternity Services Oversight Panel, Progress Report Spring 2020	

Cwm Taf Inquiry: RCOG Review					
		• reassess the quality of induction, training and supervision in obstetrics, • seek assurance on the suitability of this service for trainees, • appoint a named Royal College of Obstetricians and Gynaecologists College tutor to provide support for the trainees currently on the Royal Glamorgan Hospital site • with adequate time and resource to fulfil this function. *(April 2019)*			
	34	Allocate all trainees currently in post a clinical and educational supervisor • the role of clinical supervisor and educational supervisor should be documented and closely monitored by the Director of Medical Education, • the competency assessments for trainees must be provided in-house under the supervision of the Royal College of Obstetricians and Gynaecologists College Tutor. *(April 2019)*	Panel re-verified as complete 3.8.2020. Verification based on assessment of documentary evidence and probing conversations. (p. 31)	Independent Maternity Services Oversight Panel, Progress Report September 2020	
Improving NHS culture and governance	**35**	Undertake a training needs assessment for all staff to identify skills gaps and target additional training. *(April 2019)*	Learning Needs Analysis has been undertaken … Learning Needs Analysis plans have been drafted and approved and a launch event has taken place to promote staff awareness. (September 2022) (p. 9)	Independent Maternity Services Oversight Panel, Progress Report September 2022 <link> accessed 8/12/23	

Cwm Taf Inquiry: RCOG Review					
Improving NHS culture and governance	**36**	Clinical supervision and consultant oversight of practical procedures must be in place for all staff including specialist midwives and staff doctors. *(April 2019)*	Reviewed in 2021, and followed up in April 2022 to ensure improvements are being embedded in practice. (September 2021) (p. 41) Panel closed in April 2022: Evidence provided meets recommendation requirements.	Independent Maternity Services Oversight Panel, Progress Report September 2021 Independent Maternity Services Oversight Panel, Progress Report April 2022	
Improving NHS culture and governance	**37**	Develop an effective department wide multi-disciplinary teaching programme. • this must be adequately resourced and time allocated for attendance by all staff groups including specialist clinical midwives and SAS doctors. • attendance must be monitored and reviewed at appraisal. *(April 2019)*	Reviewed in 2021, and followed up in April 2022 to ensure improvements are being embedded in practice. (September 2021) (p. 41) Panel closed in April 2022: Evidence provided meets recommendation requirements.	Independent Maternity Services Oversight Panel, Progress Report September 2021 Independent Maternity Services Oversight Panel, Progress Report April 2022	
Improving patient safety	**38**	Ensure the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call. • this must involve the antenatal ward round being performed by the consultant. *(April 2019)*	Panel agreed as complete at 16.12.19, with ongoing checks to ensure embedded. Consolidation into one obstetric unit with increased hours of resident Labour Ward cover from 40 hours to 60 hours per week Reduction in handovers from 4 to 2 in any 24 hour period allowing for consultant Labour Ward cover (p.50)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	

Cwm Taf Inquiry: RCOG Review					
Improving NHS culture and governance	**39**	Review the working practice for how consultant cover for gynaecology services will be delivered after the merger. • a risk assessment must be performed to determine the case mix of planned surgery on the Royal Glamorgan site when there is no resident gynaecology cover. *(April 2019)*	Panel verified that recommendation delivered 22 February 2021 and determined they would review in 6 months after. (p. 39) (September 2021 report)	Independent Maternity Services Oversight Panel, Progress Report September 2021	
	40	Review the skills and competencies of the senior clinical midwives covering for tier 1 doctors to ensure: • their scope of practice is clearly defined, • the Health Board and the individuals are protected against litigation risk for their extended roles. *(April 2019)*	Reviewed in 2021, and followed up in April 2022 to ensure improvements are being embedded in practice. (September 2021) (p. 41) Administrative closure: The identified roles no longer exist.	Independent Maternity Services Oversight Panel, Progress Report September 2021 Independent Maternity Services Oversight Panel, Progress Report April 2022	
ToR 6: Review the working culture within maternity including inter-professional relationships, staff engagement and communication between health care professionals and their potential impact on improvement activities, patients' safety and outcomes.					
Improving NHS culture and governance	**41**	Consider the impact of the planned merger on the current culture of the organisation. The Board needs to carefully consider whether the planned merger of two units, both of which are described as having significant issues with their working culture, is likely to compound the problems rather than correct them. *(April 2019)*	Panel agreed as complete at 18.02.20. Action written off. Merger occurred over 12 months ago and culture is being addressed through a range of other actions. (p.76)	Independent Maternity Services Oversight Panel, Progress Report Spring 2020	

Cwm Taf Inquiry: RCOG Review					
Improving NHS culture and governance	**42**	In conjunction with Organisation Development undertake work with all grades of staff around communication, mutual respect and professional behaviours. • staff must be held to account for poor behaviours and understand how this impacts on women's safety and outcomes. *(April 2019)*	Panel verified that recommendation delivered 22 February 2021 and expected the Health Board to continue to monitor. (p. 39) (September 2021 report)	Independent Maternity Services Oversight Panel, Progress Report September 2021	
ToR 7: Identify the areas of leadership and governance that would benefit from further targeted development to secure and sustain future improvement and performance.					
Improving NHS culture and governance	**43**	Undertake an in-depth assessment of the service as it moves into the future with its new ways of working and the likelihood of an increased demand for services. • This can determine the structures and competencies of clinical leadership and governance that will support the service. *(April 2019)*	Panel agreed as complete at 18.02.20. Action written off. Merger occurred over 12 months ago. New structures have been implemented. Longer term action is being addressed elsewhere within the improvement plan (p.76)	Independent Maternity Services Oversight Panel, Progress Report Spring 2020	
Improving NHS culture and governance	**44**	Support training in clinical leadership. • The Health Board must allow adequate time and support for clinical leadership to function. *(April 2019)*	Panel closed with some outstanding elements: Improvement programme plans need to include agreed Leadership Development Plan activities. *(April 2022)* (p. 37)	Independent Maternity Services Oversight Panel, Progress Report April 2022	
Regulation and oversight of NHS managers	**45**	Provide mentorship and support to the Clinical Director • define the responsibilities of this role, • ensure there are measurable performance indicators,	Panel closed: Evidence provided meets recommendation requirements. *(April 2022)* (p. 38)	Independent Maternity Services Oversight Panel, Progress Report April 2022	

Cwm Taf Inquiry: RCOG Review					
		• ensure informed HR advice to consistently manage colleagues' absence and deployment of staff to cover the needs of the service, • consider buddying with a Clinical Director from a neighbouring Health Board. *(April 2019)*			
Improving NHS culture and governance	**46**	Appoint clinical leads in a structure that supports the service with defined role descriptions and objectives to include an individual responsible for each of the following: • governance and clinical quality to include guideline updating, • data quality, • medical staff education and training, • multi-disciplinary training, • audit, • risk management, • incident review, • complaints handling. *(April 2019)*	Panel agreed as complete at 16.12.19. Clinical leads appointed within an agreed structure, these interim arrangements now need to be formalised. All governance forums are now responsible for updating and aligning Lead consultant for Audit in place. (p.54)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	
ToR 8: Assess the level of patient engagement and involvement within the maternity services and determine if patient engagement is evident in all elements of planning and service provision. Assess whether services are patient centred, open and transparent.					
Improving patient safety	**47**	Develop and strengthen the role and capacity of the Maternity Services Liaison Committee to act as a hub for service user views and involvement of women and families to improve maternity care: • Appoint a Lay Chair as a matter of priority and increase lay membership numbers with appropriate support and resources,	Panel verified as complete 3.8.2020. (September 2020 report) (p. 33)	Independent Maternity Services Oversight Panel, Progress Report September 2020	

Cwm Taf Inquiry: RCOG Review					
		• Support lay members to engage with women using services in the Fetal Medicine Unit at Royal Glamorgan Hospital and at Prince Charles Hospital to assess satisfaction and to identify issues relating to choices, • Enhance the Maternity Services Liaison Committee monitoring role in order to assess whether patterns of concerns are found and to ask for regular feedback on action taken. *(April 2019)*			
	48	Utilise the role and strengths of the Community Health Council: • Ensure appropriate resources to act effectively as an independent advocate, • Ensure that information is available to families regarding its role and contact details, • Explore provision of Community Health Council to act as point of contact and provide direct support for women and families, in addition to acting as a conduit referring to other agencies and support, • Involve the Community Health Council in the early implementation of the new maternity facilities at Prince Charles Hospital and the Fetal Medicine Unit at Royal Glamorgan Hospital so they can be assured regarding the impact on access and satisfaction with maternity services. *(April 2019)*	Panel agreed as complete at 16.12.19. The Health Board has worked collaboratively with the Community Health Council to ensure independent advocacy support for service users. - the Community Health Council are active participants of the engagement planning meetings and have also supporting recent engagement events. (p.55)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	
Improving patient safety	**49**	Develop the range and scope of engagement with women and families.	Panel verified as complete 12.8.2020. (September 2020 report) (p. 33)	Independent Maternity Services	

Cwm Taf Inquiry: RCOG Review					
		• review the effectiveness of patient experience methodology and its impact on service change and improvement as a result of feedback, • as a priority, review and address the monitoring of the outcomes of patient experience as a key part of the governance structure, • feedback the outcomes of all engagement to women and families, • explore methods to hear directly from women and families about their experience including patient stories, diaries, 'mystery shopper' or observation techniques. *(April 2019)*		Oversight Panel, Progress Report September 2020	
	50	Continue to work with and build on the community based engagement approaches being suggested by the Maternity Services Liaison Committee. • explore working with external partners, including the Community Health Council and community based organisations. *(April 2019)*	Panel agreed as complete at 26.03.20. Lay Member actively involved in ongoing development of next steps plan. (p.77)	Independent Maternity Services Oversight Panel, Progress Report Spring 2020	
Improving the ability to raise complaints and concerns	**51**	Ensure responses to complaints and concerns is core to the work being undertaken to improve governance and patient safety: • Review and enhance staff training on the value of listening to women and families, • Review the process of investigation of concerns, compiling responses, handling 'on the spot' issues and ensure that all responses and discussions are informed by	Panel closed with all elements outstanding: Improvement programme plans need to include embedding of complaints, concerns and clinical incidents into service governance, with regular reporting, service improvements resulting from the data, and periodic thematic reports. *(April 2022) (p. 39)*	Independent Maternity Services Oversight Panel, Progress Report April 2022	

Cwm Taf Inquiry: RCOG Review					
		comprehensive investigations and accurate notes, • Prioritise the key issues that women and families have highlighted to improve the response, • Ensure that promises of sharing notes and providing reports to families are delivered, • Clarify the process regarding the triangulation of the range of information sources on patient experience, serious incidents, complaints and concerns and other data and ensure that there is a rigorous approach to make sense of patterns of safety and quality issues, • Review the learning from the serious incidents in relation to misdiagnosis, failure to seek a second opinion and inappropriate patient discharge. *(April 2019)*			
Improving NHS culture and governance	**52**	Learn from the experience of women and families affected by events • Respond and work with families in the way they require, • Feed the learning into the design of a comprehensive training and support programme that will give women and families confidence in the skills, expertise, communication, safety and quality of maternity care. *(April 2019)*	Panel verified as complete 3.8.2020. (September 2020 report) (p. 33)	Independent Maternity Services Oversight Panel, Progress Report September 2020	

Cwm Taf Inquiry: RCOG Review					
	53	Review the communications, support and engagement approach and strategy. • Ensure that the focus is not solely on management of key messages, • Demonstrate openness, honesty and transparency, admission of fault, and learning from this. *(April 2019)*	Panel verified that recommendation delivered 3 September 2021 and expected the Health Board to continue to monitor. (p. 39) (September 2021 report)	Independent Maternity Services Oversight Panel, Progress Report September 2021	
	54	Prioritise an engagement programme with families at its heart. • Women and families affected by events should be part of the improvement, co-design and culture change of the new service. *(April 2019)*	Panel verified that recommendation delivered 2 August 2021 and will review the recommendation again, in six months' time. (p. 40) (September 2021 report)	Independent Maternity Services Oversight Panel, Progress Report September 2021	
	55	Review the level and effectiveness of the bereavement service. • Ensure that appropriate support and counselling is available for all families as required, • Consider implementing the National Bereavement Care Pathway which has been developed by Sands in collaboration with stakeholders including women and their families, Royal College of Obstetricians and Gynaecologists and Royal College of Midwives. *(April 2019)*	Panel agreed as complete at 23.03.20. Lay Member actively involved in ongoing development of next steps plan. (p.77)	Independent Maternity Services Oversight Panel, Progress Report Spring 2020	
Improving NHS culture and governance	**56**	Provide training for staff in communications skills, in particular on: • Empathy, compassion and kindness. *(April 2019)*	This recommendation was closed but incomplete: the improvement programme plans need to include Culture Development Plan activities. *(April 2022) (p. 39)*	Independent Maternity Services	

Cwm Taf Inquiry: RCOG Review					
				Oversight Panel, Progress Report April 2022	
ToR 9: Consider the appropriateness and effectiveness of the improvement actions already implemented by the Health Board.					
Improving NHS culture and governance	**57**	Continue with efforts to recruit and retain permanent staff. *(April 2019)*	Panel verified as complete 3.8.2020. Verification based on assessment of documentary evidence and probing conversations. (p. 32)	Independent Maternity Services Oversight Panel, Progress Report September 2020	
Improving NHS culture and governance	**58**	Seek expert external midwifery and obstetric advice for support in developing the maternity strategy and use the opportunity of change to explore new ways of working. *(April 2019)*	Panel agreed as complete at 23.03.20. Action written off. Merger occurred over 12 months ago. New structures have been implemented. Longer term action is being addressed elsewhere within the improvement plan. (p.76)	Independent Maternity Services Oversight Panel, Progress Report Spring 2020	
	59	Urgently carry out a full risk assessment before committing to the merger on 9 March 2019 to ensure women's safety, including: • Ensuring that length of stay is reduced safely to allow for sufficient capacity in the new merged unit. *(April 2019)*	Panel agreed as complete at 16.12.19. Risk assessment prior to move undertaken. - Risk assessment reviewed at board level. (p.50)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	
Improving patient safety	**60**	Monitor the effects of the reduced inpatient capacity to avoid any adverse effects on the safety or quality of the service. *(April 2019)*	Panel agreed as complete at 16.12.19. Daily Acuity reports are completed to ensure monitoring. (p.50)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	

Cwm Taf Inquiry: RCOG Review					
Improving NHS culture and governance	**61**	Develop a plan to increase inpatient capacity if that is seen to be required. *(April 2019)*	Panel agreed as complete at 16.12.19. DATIX monitoring in use and overflow area available. (p.50)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	
Regulation and oversight of NHS managers	**62**	Independent Board members must investigate the lack of action by the Executive Team and Board following receipt of the consultant midwife's report in September 2018. • Independent Board members must challenge the executive over the contents of this report, • Independent Board members must ensure they are fully informed on the monitoring of planned improvements. *(April 2019)*	Panel verified as complete 27.8.2020. Verification based on assessment of documentary evidence and probing conversations. (p. 32)	Independent Maternity Services Oversight Panel, Progress Report September 2020	
Improving NHS culture and governance	**63**	Independent Board members must challenge the quality of the data which informs the reports which they receive and rely upon for assurance. *(April 2019)*	Closed with some outstanding elements: Development of a Maternity Service Dashboard and a data driven reporting culture is required to enable Members to make independent judgements. This needs to be encompassed in the longer-term improvement programme plans. *(April 2022)* (p. 40) In September 2022, the maternity service dashboard was relaunched and is now featuring in all governance forums with clear routes of escalation through to the Quality and Safety Committee. *(September 2022)* (p. 22)	Independent Maternity Services Oversight Panel, Progress Report April 2022	
Regulation and oversight of NHS managers	**64**	Independent Board members should receive training in the implications of The Corporate Manslaughter and Corporate Homicide Act 2007 to	Panel agreed as complete at 10.03.20. (p.76)	Independent Maternity Services	

Cwm Taf Inquiry: RCOG Review					
		better understand their role in ensuring the safety of the services which the Board provides. *(April 2019)*		Oversight Panel, Progress Report Spring 2020	
ToR 10. To make recommendations based on the findings of the review to include service improvements and sustainability. Advise on future improvements, future staffing and maintenance of quality, patient safety and assurance mechanisms.					
	65	Ensure that criteria for the opening of the new Fetal Medicine Unit have been agreed by a multidisciplinary maternity guidelines group and that readiness for the merger is assured. *(April 2019)*	Panel agreed as complete at 16.12.19. Standard Operating Procedures approval and escalation via the governance framework (p.51)	Independent Maternity Services Oversight Panel, Progress Report Winter 2020	
	66	Update the risk register and review regularly at Board level. *(April 2019)*	Panel agreed as complete 09.03.20. (p.74)	Independent Maternity Services Oversight Panel, Progress Report Spring 2020	
Improving NHS culture and governance **Improving patient safety**	**67**	Develop a strategic vision for the maternity service and use the current opportunity of change to create a modern service which is responsive to the women and their families and the staff who provide care. *(April 2019)*	A first draft of the strategy has been developed, informed by a population health assessment and consultation with staff and service users. This has been through an external clinical review reference group and has recently been signed off by the Maternity and Neonatal Improvement Board in readiness for publication. *(September 2022) (p. 9)*	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving NHS culture and governance	**68**	Consider examining other UK maternity services to seek out models for delivery which could better serve their population regarding: • methods of service delivery, • consultant delivered labour ward care, • the role of and function of a resident consultant,	Panel: *"One of the recommendations (7.68) was an action which was being managed by the Health Board. For the sake of convenience this has been included in the Quality of Leadership and Management domain."*	Independent Maternity Services Oversight Panel, Progress Report September 2020	

Cwm Taf Inquiry: RCOG Review					
		• achieving a balance between obstetrics and gynaecology commitments, • reducing the use of speciality and specialist doctors for out of hours service delivery and developing their in hours role. *(April 2019)*			
Improving NHS culture and governance	**69**	Identify and nurture the local leadership talent. *(April 2019)*	Panel verified that recommendation delivered 22 February 2021 and expected the Health Board to continue to monitor. (p. 39) (September 2021 report)	Independent Maternity Services Oversight Panel, Progress Report September 2021	
Improving NHS culture and governance	**70**	Ensure that any future service change for the development process of the maternity service as a whole is inclusive for all staff and service users. • Ensure the service is adequately staffed to ensure that all staff groups are able to participate in developing the vision • Consider an externally facilitated and supported process for review. • Consider seeking continued support from Healthcare Inspectorate Wales and the Royal Colleges to undertake a diagnostic review of the service particularly in relation to changes in service provisions. *(April 2019)*	Panel deemed administrative closure: Due to a significant overlap, this recommendation has been merged with 67. In line with recommendation 67, this has been deemed as complete by the Panel.	Independent Maternity Services Oversight Panel, Progress Report September 2022	

(b) Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office: A review of quality governance arrangements at Cwm Taf Morgannwg University Health Board (November 2019)

Cwm Taf: Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office					
Type of Recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
Recommendations to improve the strategic focus on quality, patient safety and risk					
Improving patient safety	**1**	The Health Board must agree organisational quality priorities and outcomes to support quality and patient safety. This should be reflected within an updated version of the Health Board's Quality Strategy. *(November 2019)*	Progress made by April 2021: *"The Health Board has defined what high-quality care means but [it] has been significantly delayed due to the pressures of the pandemic…the Health Board has indicated its intention to integrate the Quality Strategy into the Health Boards Integrated Health and Care Strategy which is due to be published by Autumn 2021." (p. 9)*	Joint Review by AW and HIW, A summary of progress made against recommendation (May 2021)	
Improving NHS culture and governance	**2**	The Health Board needs to take a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically: I. The Board Assurance Framework reflects the objectives set out in the current Integrated Medium Term Plan and the Health Board's quality priorities II. The Risk Management Strategy reflects the oversight arrangements for the Board Assurance Framework, the Quality and Patient Safety Governance Framework and any changes to the management of risk within the Health Board.	Progress made by April 2021: *"The Health Board has made good progress in this area through the introduction of the new risk management strategy… The Health Board has also articulated its intention, by the end of 2021, to develop a Board Assurance Report (BAR), which will detail the principal risks rather than the operational risks as currently defined in the risk register." (p. 10)*	Joint Review by AW and HIW, A summary of progress made against recommendation (May 2021)	

Cwm Taf: Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office					
		III. The Quality and Patient Safety Governance Framework must support the priorities set out in the Quality Strategy and align to the Values and Behaviours Framework IV. Terms of reference for the relevant committees, including the Audit Committee, Quality, Safety and Risk Committee, and Clinical Business Meetings, reflect the latest governance arrangements cited within the relevant strategies and frameworks. *(November 2019)*			
Recommendations for leadership of quality and patient safety					
Improving NHS culture and governance **Regulation and oversight of NHS managers** **Improving patient safety**	**3**	Ensure there is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads: I. Strengthening of the role of the Medical Director and Clinical Directors in relation to quality and patient safety II. Clarify the roles, responsibilities, accountability and governance in relation to quality and patient safety within the directorates III. Ensure there is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety. *(November 2019)*	Progress made by April 2021: *"Collective responsibility for Quality and Safety is now shared by the four clinical executive directors…This is clearly set out in the Health Board's Quality Governance Framework. […] The Quality Governance Framework aligns to the operating model that was introduced in April 2020." (pp. 12-13)*	Joint Review by AW and HIW, A summary of progress made against recommendation (May 2021)	
Recommendations for organisational scrutiny of quality and patient safety					

Cwm Taf: Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office					
Improving patient safety	**4**	The roles and function of the Quality, Safety and Risk Committee need to be reviewed to ensure it is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety Governance Framework and key corporate [organisational risks] for quality and patient safety. This should include the following: I. Implement the sub-groups to support Quality, Safety and Risk Committee must be completed ensuring there is sufficient support (administratively and corporately) to enable these groups to function effectively II. Improvements to the content, analysis, clarity and transparency of information presented to Quality, Safety and Risk Committee III. Focus should be given to ensure the Quality and Patient Safety Governance Framework is used to improve oversight of quality and patient safety across the whole organisation, including Bridgend services. This should be accompanied by the necessary resource for its timely implementation, internal communications and training. *(November 2019)*	Progress made by April 2021: *"Although some aspects of this recommendation have been superseded, there has been good progress with establishing the new governance framework and reporting.* *"Our observations of Board and Quality and Safety committee meetings found appropriate levels of scrutiny and challenge with candid responses from officers. The improvements to the quality reports are positive and … but fall short of setting targets or thresholds where further work or escalation may occur" (pp. 14-15)*	Joint Review by AW and HIW, A summary of progress made against recommendation (May 2021)	
Improving NHS culture and governance	**5**	Independent members must be appropriately supported to meet their responsibilities through the provision of an adequate induction programme and	Progress made by April 2021: "Independent Members receive appropriate support through the provision of an induction programme and	Joint Review by AW and HIW, A summary of progress made	

Cwm Taf: Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office					
		ongoing development so they can effectively scrutinise the information presented to them. *(November 2019)*	ongoing development to support them in their scrutiny role." *(p. 15)*	against recommendation (May 2021)	
Improving patient safety	**6**	There needs to be sufficient focus and resources given to gathering, analysing, monitoring and learning from patient experience across the Health Board. This must include use of real-time patient feedback. *(November 2019)*	Progress made by April 2021: "the Health Board began the development of a comprehensive three-year Patient Experience Strategy, however, its completion and implementation has been impeded by the pandemic response, and we have not received an update on its progress and a completion date from the Health Board in this regard" *(p. 16)*	Joint Review by AW and HIW, A summary of progress made against recommendation (May 2021)	
Improving NHS culture and governance	**7**	There needs to be improved visibility and oversight of clinical audit and improvement activities across directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning. *(November 2019)*	Progress made by April 2021: *"Good progress has been made by the Health Board in addressing visibility and oversight of clinical audit, but it could be better targeted to areas of organisational risk." (p. 18)*	Joint Review by AW and HIW, A summary of progress made against recommendation (May 2021)	
Recommendations to improve the arrangements for quality and patient safety at directorate level					
Regulation and oversight of NHS managers	**8**	The Health Board needs to clarify accountabilities and responsibilities for quality and patient safety within directorates. This must include a review of the Heads of Nursing role in relation to site management and quality and patient safety. *(November 2019)*	Progress made by April 2021: *"Whilst the Health Board has taken steps to address this recommendation, these improvements remain at an early stage and still need attention to ensure they are being embedded across the organisation." (p. 20)*	Joint Review by AW and HIW, A summary of progress made against recommendation (May 2021)	
Improving NHS culture and governance	**9**	The form and function of the directorate governance committees and clinical business meetings must be reviewed to ensure there is:	Progress made by April 2021: *"Governance arrangements at an operational level have been strengthened. Since our 2019 review CBMs have been removed following the introduction of the new*	Joint Review by AW and HIW, A summary of progress made	

Cwm Taf: Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office					
		I. Clear remit, appropriate membership and frequency of these meetings II. Sufficient focus, analysis and scrutiny of information in relation to quality and patient safety issues and actions III. Clarity of the role and decision making powers of the clinical business meetings. *(November 2019)*	*operating model. This recommendation is therefore superseded." (p. 21)*	against recommendation (May 2021)	
Recommendations to improve the identification and management of risk					
	10	The Health Board must ensure there are clear and comprehensive risk management systems at directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers. This must be reflected in the risk strategy. *(November 2019)*	Progress made by April 2021: *"The product of this work was the revised organisational risk register, which was presented to the Board in November 2020. This is a significant improvement since the previous risk register, however there is recognition within the Health Board that more work is needed to improve the mitigations and actions as described." (p. 22)*	Joint Review by AW and HIW, A summary of progress made against recommendation (May 2021)	
Improving NHS culture and governance	**11**	The oversight and governance of DATIX must be improved so that it is used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a directorate or corporate level, and formal mechanisms to identify and share learning. *(November 2019)*	Progress made by April 2021: *"Whilst the Health Board has informed us that since our work it has developed investigation and serious incident trackers to enhance monitoring in relation to incident management, more work is required to ensure that opportunities are taken for identifying early learning following incidents." (p. 24)*	Joint Review by AW and HIW, A summary of progress made against recommendation (May 2021)	
Improving the ability to raise	**12**	The Health Board must ensure staff receive appropriate training in the investigation and management of concerns. In addition, directorate	Progress made by April 2021: "*Whilst the Health Board has made progress with addressing this recommendation, oversight of training*	Joint Review by AW and HIW, A summary of	

Cwm Taf: Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office					
complaints and concerns		staff need to be empowered to take ownership of concerns and take forward improvement actions and learning. *(November 2019)*	*corporately, and within each ILG, requires further attention*." *(p. 27)*	progress made against recommendation (May 2021)	
Recommendations for organisational culture and learning					
	13	The Health Board must ensure the timely development of a Values and Behaviours Framework with a clear engagement programme for its implementation. *(November 2019)*	Progress made by April 2021: *"The Health Board has made good progress in developing and rolling out its Values and Behaviours Framework, although it has needed to adjust the implementation timescales because of the pandemic." (p. 28)*	Joint Review by AW and HIW, A summary of progress made against recommendation (May 2021)	
Improving NHS culture and governance	**14**	The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken in the Princess of Wales Hospital. *(November 2019)*	Progress made by April 2021: "However, there is limited evidence to demonstrate that wider learning beyond the clinical area being inspected is shared effectively across all other clinical areas and with staff, particularly with those on the front line who are responsible for day-to-day care of patients." *(p. 30)*	Joint Review by AW and HIW, A summary of progress made against recommendation (May 2021)	

(c) Independent Review of Neonatal Services at Prince Charles Hospital (January 2022)

Cwm Taf: Independent Review of Neonatal Services at Prince Charles Hospital					
Type of Recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
Immediate Escalation of Concerns – Interim Recommendations					
Improving patient safety	**ESC 1**	The Health Board must introduce immediate make safes to support safe prescribing in practice. *(January 2022)*	Complete – April 2022. Staff training for all staff on prescribing. Staff refuse prescriptions that don't follow the good prescribing guide. (p. 44)	Independent Maternity Services Oversight Panel, Progress Report April 2022	
Improving NHS culture and governance	**ESC 2**	The Health Board must continue to show an improvement in the working relationship with maternity services in numerous areas. *(January 2022)*	September 2022. Agreed minimal interventions in progress, e.g. standardised ongoing audit and feedback mechanism to clinical teams, Board and network regarding cases. (p. 74)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving patient safety	**ESC 3**	The Health Board must ensure consultant cover for the neonatal service is safe and effective. *(January 2022)*	Complete - September 2022. Consultants with neonatal interest must have protected time to ensure the neonatal service is covered by senior medical staff. (p. 44)	Independent Maternity Services Oversight Panel, Progress Report April 2022	
Improving patient safety	**ESC 4**	The Health Board must ensure immediate improvements are implemented to support expert clinical decision making for the sickest and most vulnerable patients in the service. *(January 2022)*	Complete - September 2022. Referral threshold for advice from a nominated neonatal intensive care unit should be clearly articulated for all clinical staff. (p. 75)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
	ESC 5	The Health Board must review its cooling practice in line with national frameworks and ensure local practice meets this standard.	September 2022. Agreed minimal interventions in progress. Standards of documentation around decision making for cooling should include as a minimum. (p. 75)	Independent Maternity Services	

Cwm Taf: Independent Review of Neonatal Services at Prince Charles Hospital					
		(January 2022)		Oversight Panel, Progress Report September 2022	
	ESC 6	The Health Board should immediately review all cases of unplanned extubation occurring in the service. *(January 2022)*	Complete - September 2022. Datix/audit for all unplanned extubations, changes in securing practice to prevent extubations. (p. 75)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving NHS culture and governance	**ESC 7**	The Health Board must ensure clinical incident reviews, serious incident reviews and Perinatal Mortality Review Tool/Mortality reviews are carried out as a multi-disciplinary team with external support from colleagues within the local neonatal intensive care unit to provide clinical expertise and questioning. *(January 2022)*	September 2022. Agreed minimal interventions in progress, e.g., establish and monitor SI processes seeking additional clinical expertise when required to support local learning regarding what a good review looks like. (p. 76)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving patient safety	**ESC 8**	The Health Board continue to progress a robust mechanism for reviewing all term admissions to the neonatal unit alongside obstetric and maternity colleagues. *(January 2022)*	Complete - September 2022. Agreed minimal intervention achieved - ensured all radiology imaging is reviewed and interpretation documented by a consultant within the neonatal service. (p. 76)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving patient safety	**ESC 9**	The Health Board should review current formal radiology reporting mechanisms and request an external review by a paediatric radiologist with neonatal experience to highlight areas of concern. *(January 2022)*	Complete - September 2022. Agreed minimal intervention achieved. (p. 76)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
	ESC 10	The Health Board must undertake and immediate documentation review and introduce supportive	Complete - September 2022. Agreed minimal intervention achieved e.g. Communication and education/training for all staff regarding standards of	Independent Maternity Services	

Cwm Taf: Independent Review of Neonatal Services at Prince Charles Hospital					
		documents to assist in improving documentation standards. *(January 2022)*	documentation as per governing bodies. (p. 77)	Oversight Panel, Progress Report September 2022	
	ESC 11	The Health Board should consider actions to support working with families to understand the impact of the listening exercise and improving family involvement in the service. *(January 2022)*	Complete - September 2022. Agreed minimal intervention achieved e.g. review and organised family feedback into themes and a useable review format. (p. 77)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving NHS culture and governance	**ESC 12**	The Health Board must improve the staff culture on the unit to ensure all staff feel valued and listened to. *(January 2022)*	Complete - September 2022. Agreed minimal intervention achieved e.g. staff engagement exercise undertaken. (p. 77)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving patient safety	**ESC 13**	The Health Board improvement hub and clinical teams must work together to understand the common goal of a safer service. *(January 2022)*	Complete - September 2022. Agreed minimal intervention achieved e.g. clinical team must be supported to take ownership of the service and understand their role within improvements. (p. 77)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving NHS culture and governance	**ESC 14**	The Health Board must introduce a clear audit structure to monitor improvement and evidence the effectiveness of the service. *(January 2022)*	Complete - September 2022. Agreed minimal intervention achieved e.g. clinically led audit system that identifies, prioritises, plans, undertakes, monitors, and reviews audit outputs. (p. 78)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Core Recommendations					
1. Family Engagement and Support					
	1.1	The Health Board should complete and implement its family involvement and engagement strategy at pace and provide a robust mechanism for family	As this did not require immediate action, this was incorporated into a detailed plan which addresses all of the recommendations emerging from the deep-dive review.	Independent Maternity Services	

Cwm Taf: Independent Review of Neonatal Services at Prince Charles Hospital					
		feedback that is compatible with the mature engagement approach developed across maternity services. The strategy should be personalised to the needs of women and families using perinatal services and build upon feedback from both current and past service users. *(January 2022)*	The Panel has not externally evaluated delivery, but the Health Board confirmed to the Panel broadly that recommendations from this review have largely been implemented, albeit there are elements which require further follow-up, evaluation and embedment. (pp. 23-24)	Oversight Panel, Progress Report September 2022	
	1.2	Current breastfeeding support should be reviewed to ensure there is sufficient capacity to meet the needs of service users. *(January 2022)*			
	1.3	Peer support networks should be developed for families both within neonatal services and following discharge. *(January 2022)*			
	1.4	The neonatal service should have dedicated psychological provision to support families and staff. *(January 2022)*			
	1.5	A framework for Family Integrated Care should be implemented and its impact evidenced. *(January 2022)*			
2. Governance, Assurance and Accountability					
Improving patient safety	**2.1**	Health Board governance processes need to demonstrate sustained achievement of improved safety and clinical effectiveness within the neonatal service. *(January 2022)*	As this did not require immediate action, this was incorporated into a detailed plan which addresses all of the recommendations emerging from the deep-dive review. The Panel has not externally evaluated delivery, but the Health Board confirmed to the Panel broadly that recommendations from this review have largely been implemented, albeit there are elements which require further follow-up, evaluation and embedment. (pp. 23-24)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving NHS culture and governance	**2.2**	The Health Board must improve its ward to Board assurance processes with specific focus on the quality of incident reviews and how any safety-critical findings are identified and shared through the Integrated Locality Group governance			

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		structures to the Board. This must demonstrate sustained advances in the safety and effectiveness of neonatal service provision at Prince Charles Hospital. *(January 2022)*			
	2.3	Evidence of detailed discussions taking place regarding clinical outcomes and clinical audit should be provided to the Integrated Locality Group and Health Board committees to ensure Executive level oversight of clinical performance and trajectory. *(January 2022)*			
	2.4	Clinical audit needs to be valued, resourced and utilised at all levels and must be of a high quality to promote confidence in applying findings to developing services. *(January 2022)*			
3. Neonatal Service Workforce					
	3.1	British Association of Perinatal Medicine (BAPM) standards should be adhered to for both nursing and medical workforce provision and structure. *(January 2022)*	As this did not require immediate action, this was incorporated into a detailed plan which addresses all of the recommendations emerging from the deep-dive review. The Panel has not externally evaluated delivery, but the Health Board confirmed to the Panel broadly that recommendations from this review have largely been implemented, albeit there are elements which require further follow-up, evaluation and embedment. (pp. 23-24)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving NHS culture and governance	**3.2**	Extra consultant time needs to be provided to allow for a consultant of the week pattern from 09:00 - 17:00. All consultants who cover the unit on call should have a minimum of four neonatal service weeks per annum. *(January 2022)*	**Position: Complete** Agreed minimal intervention reached - Review of medical workforce conducted following the deep-dive Escalation with associated action plan. (p. 49) *(April 2022)*	Independent Maternity Services Oversight Panel, Progress Report April 2022	

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Improving culture and governance NHS	**3.3**	There should be investment in a Neonatal Unit Senior Nurse position who is in part Matron and part Improvement Lead Nurse to ensure there is a stable senior nursing leadership structure with the specialist ability and leadership experience to know and deliver 'what good looks like'. *(January 2022)*	As this did not require immediate action, this was incorporated into a detailed plan which addresses all of the recommendations emerging from the deep-dive review. The Panel has not externally evaluated delivery, but the Health Board confirmed to the Panel broadly that recommendations from this review have largely been implemented, albeit there are elements which require further follow-up, evaluation and embedment. (pp. 23-24)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving culture and governance NHS	**3.4**	The Advanced Neonatal Nurse Practitioner team should be expanded with clear career progression including protected time for development within the four pillars of advanced practice. Tier 1, Tier 2 and nurse consultant roles should be explored. *(January 2022)*			
Improving culture and governance NHS	**3.5**	There should be rotation of nursing and medical teams to exemplar Neonatal Units to support maintenance of competence in key clinical skills and decision making. *(January 2022)*			
Improving culture and governance NHS	**3.6**	Additional investment is required for nursing quality roles. Resilience needs to be developed, for example by ongoing internal rotation of Neonatal Unit staff into these roles. *(January 2022)*			
Improving culture and governance NHS	**3.7**	Additional investment is required to enable the nurse in charge role to be supernumerary. *(January 2022)*			
Improving culture and governance NHS	**3.8**	There should be adequate provision for Allied Health Professionals for neonatal services in line with national recommendations. These roles should be integrated within the Neonatal Unit permanent workforce. *(January 2022)*			

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Improving NHS culture and governance	**3.9**	There needs to be an expansion of clinical pharmacist resource dedicated to the neonatal service, including capacity for networking to develop expertise and exemplar practice within the Neonatal Unit. *(January 2022)*	**Position: Complete** Agreed minimal intervention reached, e.g - Protected, allocated pharmacist time for supporting education and training for all staff involved in prescribing and administering medication within neonatal care. (p. 49) *(April 2022)*	Independent Maternity Services Oversight Panel, Progress Report April 2022	
Improving NHS culture and governance	**3.10**	Mandatory training compliance needs to improve across all staff groups. This needs to be facilitated within working hours. *(January 2022)*	As this did not require immediate action, this was incorporated into a detailed plan which addresses all of the recommendations emerging from the deep-dive review. The Panel has not externally evaluated delivery, but the Health Board confirmed to the Panel broadly that recommendations from this review have largely been implemented, albeit there are elements which require further follow-up, evaluation and embedment. (pp. 23-24)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving NHS culture and governance	**3.11**	Nursing, midwifery and medical Newborn Life Support instructors need to be identified within the Health Board to support robustness in Newborn Life Support local training and simulation training. *(January 2022)*			
Improving NHS culture and governance	**3.12**	A specific nurse teaching programme should be developed, linking into network nurse teaching. *(January 2022)*			
Improving NHS culture and governance	**3.13**	There should be a robust system for clinical supervision within the workforce linked to annual appraisal and training needs analysis for the Neonatal Unit. This should be provided in a safe and supportive manner. *(January 2022)*			
Improving patient safety	**3.14**	Simulation training should use case examples to support learning in practice as a perinatal multidisciplinary team. Scenarios including intubation with drug preparation must include all levels of nursing and medical colleagues. *(January 2022)*			

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Improving patient safety	**3.15**	Simulation training should be joint with all professionals involved within perinatal services locally and the wider perinatal network. Simulations should use case examples to support learning in practice. *(January 2022)*			
4. Neonatal Unit Safety					
Improving NHS culture and governance	**4.1**	Learning from incidents needs to ensure the context of the incident and potential for human factors are considered and explored. *(January 2022)*	As this did not require immediate action, this was incorporated into a detailed plan which addresses all of the recommendations emerging from the deep-dive review. The Panel has not externally evaluated delivery, but the Health Board confirmed to the Panel broadly that recommendations from this review have largely been implemented, albeit there are elements which require further follow-up, evaluation and embedment. (pp. 23-24)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving NHS culture and governance	**4.2**	Work to better understand and develop a culture focused on safety, awareness and communication across the perinatal multidisciplinary team needs to be undertaken. *(January 2022)*			
Improving NHS culture and governance	**4.3**	Reflective practice must be included within unit learning and incident reviews. This can be both personal and multidisciplinary. *(January 2022)*			
5. Wales And National Reporting					
	5.1	The clinical team must ensure completeness and accuracy of Neonatal Unit data. *(January 2022)*	**Position: Work in progress** Agreed minimal intervention not yet reached, e.g - Senior clinicians to review neonatal data to ensure internal assurance can be provided to the Board and its Committee. (p.79) *(September 2022)*	Independent Maternity Services Oversight Panel, Progress Report September 2022	
	5.2	Neonatal dashboards should encompass a range of performance and quality metrics, supplemented with a narrative highlighting key points and identifying trends. The responsibility for this lies with the senior clinical team. *(January 2022)*	As this did not require immediate action, this was incorporated into a detailed plan which addresses all of the recommendations emerging from the deep-dive review. The Panel has not externally evaluated delivery, but the Health Board confirmed to the Panel broadly that	Independent Maternity Services Oversight Panel, Progress Report September 2022	

Cwm Taf: Independent Review of Neonatal Services at Prince Charles Hospital					
			recommendations from this review have largely been implemented, albeit there are elements which require further follow-up, evaluation and embedment. (pp. 23-24)		
6. Neonatal Unit Functionality					
Improving NHS culture and governance	**6.1**	There needs to be joint ownership of assurance and governance of aspects of care that are co-dependent on neonatal and maternity services via the Integrated Locality Group governance processes. *(January 2022)*	As this did not require immediate action, this was incorporated into a detailed plan which addresses all of the recommendations emerging from the deep-dive review. The Panel has not externally evaluated delivery, but the Health Board confirmed to the Panel broadly that recommendations from this review have largely been implemented, albeit there are elements which require further follow-up, evaluation and embedment. (pp. 23-24)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving NHS culture and governance	**6.2**	The working arrangements of the Neonatal and Maternity Improvement Teams should be reviewed to ensure effective joint working which addresses current issues related to silo working in clinical care. *(January 2022)*			
Improving NHS culture and governance	**6.3**	Neonatal and maternity teams must work together at all levels to support changes in service delivery. These include appropriate place of delivery, reducing term admissions and developing Transitional Care provision; specified consultant staff should have named responsibility for each of these elements and should be led in conjunction with designated members of the nursing and midwifery teams. *(January 2022)*			
	6.4	All developments across perinatal care must involve an appropriately diverse service user voice at national, network and local levels. *(January 2022)*			
7. Clinical Case Assessments					

Cwm Taf: Independent Review of Neonatal Services at Prince Charles Hospital					
	7.1	Communication with families on the Neonatal Unit must be timely, open and honest and comprehensively documented. *(January 2022)*	**Position: Complete** Agreed minimal intervention reached, e.g - families must be spoken to prior to transfer of baby to the neonatal unit and this should be recorded in the notes. (p.79) *(September 2022)*	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving patient safety	**7.2**	Support is required from tertiary neonatal services to support immediate clinical decision making in cases where infants require short term stabilisation and intensive care. There should be clear escalation processes in place and a trigger list to support early recognition of the need to refer. *(January 2022)*	As this did not require immediate action, this was incorporated into a detailed plan which addresses all of the recommendations emerging from the deep-dive review. The Panel has not externally evaluated delivery, but the Health Board confirmed to the Panel broadly that recommendations from this review have largely been implemented, albeit there are elements which require further follow-up, evaluation and embedment. (pp. 23-24)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving NHS culture and governance	**7.3**	Prescribing standards must be improved with a continued focus at identifying, resolving and minimising prescription errors. There needs to be clear accountability for all staff involved in prescribing and administering medicines and should be supported through the additional pharmacy support on a daily basis. *(January 2022)*			
Improving patient safety	**7.4**	Management of therapeutic hypothermia should be supported with robust guidance in line with national best practice frameworks. *(January 2022)*			
	7.5	Standards of formal radiology reporting pertaining to the neonatal services should be audited. *(January 2022)*			
Improving NHS culture and governance	**7.6**	Documentation standards must be improved in line with General Medical Council/Nursing and Midwifery Council requirements and there must be	**Position: Complete** Agreed minimal intervention reached, e.g - Regular monthly document standards audit being undertaken and reported. (p.79)	Independent Maternity Services	

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		senior medical oversight of discharge summaries. *(January 2022)*	*(September 2022)*	Oversight Panel, Progress Report September 2022	
Improving patient safety	**7.7**	The incident reporting trigger list should be followed to ensure reporting and subsequent multidisciplinary review of all significant events, for example babies requiring therapeutic hypothermia. *(January 2022)*	As this did not require immediate action, this was incorporated into a detailed plan which addresses all of the recommendations emerging from the deep-dive review. The Panel has not externally evaluated delivery, but the Health Board confirmed to the Panel broadly that recommendations from this review have largely been implemented, albeit there are elements which require further follow-up, evaluation and embedment. (pp. 23-24)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving NHS culture and governance	**7.8**	There are several areas of focus for local quality improvement projects including reducing unplanned extubation and optimising perinatal care. National toolkits should be used locally, and multidisciplinary involvement is required for success in these areas.			
Improving NHS culture and governance	**7.9**	External support should be used to ensure standards of robust review that support local learning and improvement. *(January 2022)*			
8. Wider Considerations					
Improving NHS culture and governance	**8.1**	A review of neonatal critical care services in Wales is suggested. This should include capacity, patient flows, transport services and the network's role within operational consistency and assurance. *(January 2022)*	As this did not require immediate action, this was incorporated into a detailed plan which addresses all of the recommendations emerging from the deep-dive review. The Panel has not externally evaluated delivery, but the Health Board confirmed to the Panel broadly that recommendations from this review have largely been implemented, albeit there are elements which require further follow-up, evaluation and embedment. (pp. 23-24)	Independent Maternity Services Oversight Panel, Progress Report September 2022	
Improving patient safety	**8.2**	Healthcare providers and commissioners need to actively look at high risk clinical services and seek assurance that outcomes are in line with national standards and that services are safe. Where			

Cwm Taf: Independent Review of Neonatal Services at Prince Charles Hospital					
		standards cannot be met, this should be shared transparently within an organisation and escalated so that services can be supported to improve. *(January 2022)*			
Improving NHS culture and governance	**8.3**	Maternity and Neonatal Networks should be responsible for oversight of outcomes and key safety metrics. *(January 2022)*			
	8.4	The Welsh Government may wish to consider the applicability of the recommendations made within this report to other neonatal services. *(January 2022)*			

26 PATERSON INQUIRY

26.1 Introduction

The Paterson inquiry was commissioned by the Government in December 2017, in response to the malpractice of Ian Paterson, a surgeon in the West Midlands. Paterson was convicted in April 2017 of wounding with intent patients in his care. The purpose of the Inquiry was to investigate Paterson's malpractice, but also to make recommendations and findings in key areas: safety and quality of care; responding when things go wrong; working with others to keep patients safe; and governance, accountability and culture.

Serious questions were first raised about Paterson's practice in 2003. There was also a period of suspension in 1996 after he exposed a patient to harm in one of his operations. He was ultimately suspended in 2011 from practising. In April 2017, he was convicted of 17 counts of wounding with intent and three counts of unlawful wounding relating to nine women and one man, whom he had treated as private patients between 1997 and 2011. The issues had arisen both in NHS hospitals and in private hospitals; albeit the regulator for both NHS hospitals and the independent sector is the same, namely the Care Quality Commission.

The Inquiry report was published in February 2020. The chair was The Right Reverend Graham James, then the Bishop of Norwich. It was a non-statutory inquiry. The report can be viewed online.

26.2 Paterson Inquiry: Table of Recommendations

Paterson Inquiry						
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**	**DHSC comments**
Improving patient safety **Improving the ability to raise complaints and concerns**	**P1**	**Information to patients:** The giving of information to patients about the practice of a consultant, information in GP letters, and the differences between NHS and the independent sector, should be improved. Action 1.1: There should be a single repository of the whole practice of consultants across England, setting out their practising privileges and other critical consultant performance data, for example, how many times a consultant has performed a particular procedure and how recently. This should be accessible and understandable to the public. It should be mandated for use by managers and healthcare professionals in both the NHS and independent sector. Action 1.2: It should be standard practice that consultants in both the NHS	Action 1.1: Accepted in principle by the government. In 2018, the Acute Data Alignment Programme (ADAPt) was launched to move towards a common set of standards for data collection, performance measure methodologies and reporting systems across the NHS and the independent sector. It moved into full implementation in December 2022. The data will be made available for managers and healthcare professionals. Commitment over the next 12 months to reach a decision on what information can be published. There are challenges in a single repository which require further work across the system. The National Consultant Information Programme was established and as of December 2022 was on track to meet the	**Government response document:** Published 16 December 2021 **12-month government implementation progress update:** Published 15 December 2022 **Private Health Information Network Roadmap/Delivery Plan:** Published July 2022 **2018 Guidance from the Academy of Medical Royal Colleges regarding patient letters** **As incorporated in the National Institute**		Action 1.1 Data on consultants is collected separately by the NHS and private sector. NHS Digital (now merged with NHSE) collects information relating to NHS-funded care. Private sector healthcare providers must submit information to the PHIN under mandates from the CMA, which includes consultant-level data and information on inpatient and day case activity. PHIN published its roadmap and delivery plan for 2022-2026 to meet its mandate to publish performance data on independent sector consultants. In 2018, SofS launched "ADAPt", a joint

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		and the independent sector should write to patients, outlining their condition and treatment, in simple language, and copy this letter to the patient's GP, rather than writing to the GP and sending a copy to the patient. Action 1.3: The differences between how the care of patients in the independent sector is organised and the care of patients in the NHS is organised, is explained clearly to patients who choose to be treated privately, or whose treatment is provided in the independent sector but funded by the NHS. This should include clarification of how consultants are engaged at the private hospital, including the use of practising privileges and indemnity, and the arrangements for emergency provision and intensive care. (February 2020)	original commitment of reaching all NHS hospitals over a 3-year period. The Private Health Information Network (an existing body) has published a roadmap and delivery plan (2022-2026) to meet the rest of its mandate to publish performance data on consultants in the independent sector by 2026. The Health and Care Act 2022 permits NHS Digital to require information from healthcare providers. Action 1.2: Accepted by the government. Guidance was published in 2018 and 2021 stating that consultants should write directly to patients in a way they understand. The next 12 months will explore how to make the process of writing to patients easier for professionals and how to monitor this. Action 1.3: Accepted by the government.	**for Health and Care Excellence guidance on shared decision-making (June 2021):** See para 1.2. The guidance applies to all healthcare professionals. **Professional Record Standards Body guidance on outpatient letters** **The above is incorporated into the NHS Standard Contract**		programme between NHS Digital and PHIN which aims to provide a common set of standards for data collection, performance measures and reporting across NHS and private healthcare. The ADAPt programme to establish flow of NHS and private sector procedure data is progressing. ADAPt is due to begin supplying data to NHS servers in January 2024. On ensuring accessibility of data relating to consultant performance, the National Consultant Information Programme (NCIP) is being implemented across England. NCIP provides a secure online portal which enables NHS consultants/surgeons to review information about their clinical activity and benchmark patient outcomes. As of 14 December 2023, there are

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			The government will commission the production of independent information to make people aware of the ways in which their private care is organised differently from the arrangements in the NHS. Created in partnership with patients, families and carers, this will be published in 2022, and will include expert views on a range of relevant areas that are backed by data and evidence.			130 (of 136 in scope) Trusts with access to NCIP across at least one surgical speciality. During 2024, NCIP will roll out to at least another 11 specialities. NCIP intends to collect data from private patients treated in the IS received from PHIN (timescale to be confirmed). But the aim of NCIP is to publish the number and type of cases consultants perform to ensure consultants are carrying out procedures in the IS they are also doing in the NHS. In 2022, NHSE established a central Outcome Registries Platform to receive the mandated Medical Device Outcome Registry ("MDOR") data collection, to capture and use data from NHS and private healthcare providers to detect/predict issues relating to patient safety

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						and outcomes and prevent harm to future patients. MDOR is collecting data on procedures involving high risk medical devices and includes full attribution of clinicians to the operation. NHSE is implementing the NHS Digital Staff Passport, which will enable postgraduate doctors in training, and staff who move temporarily to move between different NHS organisations more easily and quickly. NHS England will work with stakeholders such as PHIN on the potential to receive information on consultants' practising privileges. Action 1.2 In 2018, the Academy of Medical Royal Colleges (AoMRC) published guidance which states that letters should be written

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						directly to patients, copying their GP (and provides a template). In December 2021, the AoMRC, the Professional Record Standards Body (PRSB) and NHSE wrote to their members to remind them of best practice when writing to patients, referring to AoMRC's guidance. In October 2021, the PRSB updated its guidance on standard outpatient letters to make it clear that it is best practice for most outpatient letters to be written directly to the patient. The NHS Standard Contract states that outpatient letters should be consistent with PRSB's standards. The AoMRC's guidance is also reflected in NICE guidance on shared decision making. All NHS and Independent Sector (IS) providers are regulated by

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						CQC and assessments include how services ensure that patients understand and are involved in decisions regarding their care. As per the Competition and Markets Authority's (CMA) Order, private healthcare providers must send letters to patients prior to consultations or further tests and treatments setting out the costs, reasons and other relevant information regarding the procedure. The GMC updated its Good Medical Practice guidance to include communicating effectively with patients, which came into effect in January 2024. Action 1.3 In January 2020, the Independent Healthcare Provider Network (IHPN) and the Patients Association jointly

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						published a short video on what to expect from independent healthcare. IHPN has committed to produce more resources. DHSC plans to publish information on the difference in how care is organised between the NHS and IS. Given the breadth and complexity of the health and care system, this information will focus on hospital-based care in the first instance. Once published, DHSC will work with providers in both the NHS and the IS to signpost this information as part of the general information patients receive about their care.
Improving patient safety	**P2**	**Consent:** The existing guidance that patient consent must be voluntary, informed, and capacitous was insufficient to stop patients feeling under pressure. Action 2.1: There should be a short period introduced into the	Action 2.1: Accepted in principle by the government. There is no defined period required but key organisations such as the General Medical Council and the Care Quality Commission have indicated in their	**12-month government implementation progress update:** Published 15 December 2022		Action 2.1 Key organisations including the GMC and NHSE have updated their guidance, including to confirm that doctors should give patients

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		process of patients giving consent for surgical procedures, to allow them time to reflect on their diagnosis and treatment options. It is recommended that the General Medical Council monitors this as part of 'Good Medical Practice'. (February 2020)	guidance that there should be sufficient time to consider options before making a treatment decision. Doctors must provide supporting information that they are continuing to meet the principles and values in 'Good medical practice' during annual appraisals.	Revised guidance from the General Medical Council (November 2020) **Royal College of Surgeons in England 2018 guidance** **NHS delivery plan regarding Covid-19 backlog includes a reflection period on consent** **Refreshed Independent Healthcare Providers Network framework for clinical governance in the independent sector**		sufficient time to consider options before making a decision about their treatment and care. NHSE is implementing a 2-stage shared decision making process, which includes a period of reflection for patients when deciding on treatment and giving consent. NHSE has published 11 decision support tools for patients on treatment options and continues to produce further decision support tools. The GMC has revised guidance on decision making and consent that came into effect from 9 November 2020. In 2018, the Royal College of Surgeons (RCS) published guidance on consent and supported decision-making. As outlined in the RCS' "Good surgical practice" patients should sign a consent form at the end of the discussion if they have decided to go ahead with

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						treatment. The IHPN has updated the Medical Practitioners Assurance Framework ("MPAF") with standards for patient consent. Compliance with consent standards is enforced by the medical regulators. The GMC sets/enforces the standards doctors must follow as part of "Good Medical Practice". A serious or persistent failure to follow guidance that poses a risk to patient safety will put the doctor's registration at risk. If a doctor's practice regarding consent needs improvement, the GMC would require them to undertake professional development. CQC takes into account GMC and RCS guidance and standards when conducting assessments. CQC can take action if a provider is failing to ensure

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						that consent is being obtained lawfully.
Improving patient safety	**P3**	**Multidisciplinary team (MDT):** Every patient with breast cancer should have their case discussed at a properly convened Multidisciplinary Team meeting in line with national guidance. Action 3.1: The Care Quality Commission, as a matter of urgency, should assure itself that all hospital providers are complying effectively with up-to-date national guidance on Multidisciplinary Team meetings, including in breast cancer care, and that patients are not at risk of harm due to non-compliance in this area. (February 2020)	Action 3.1: Accepted by the government. The Care Quality Commission has now added more detailed and specific prompts on multidisciplinary teamworking to the inspection framework for diagnostic imaging services in NHS and independent acute hospitals.	**Government response document:** Published 16 December 2021 **12-month government implementation progress update:** Published 15 December 2022 **Updated national guidance for cancer alliances:** Published January 2020 **Updated Care Quality Commission Guidance**		Action 3.1 This recommendation has been implemented. CQC has incorporated specific prompts on MDT working into its existing inspection framework for all registered IS providers, including detailed questions on practical arrangements for MDTs with reference to appropriate national guidance. CQC's inspection frameworks for IS and NHS providers continue to include detailed questions on practical arrangements for MDTs and reference appropriate national guidance. CQC's new regulatory model which is being rolled out in 2023 will include continued effective monitoring of MDT use.

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Improving the ability to raise complaints and concerns	**P4**	**Complaints:** NHS and private patients should be fully informed about the complaints process. There should be a means for all private patients to seek independent investigation / adjudication of their complaints. Action 4.1: Information about the means to escalate a complaint to an independent body should be communicated more effectively in both the NHS and independent sector. All private patients should have the right to mandatory independent resolution of their complaint. (February 2020)	Action 4.1: Accepted by the government / accepted in principle so far as mandatory independent resolution for private patients. The Parliamentary and Health Service Ombudsman is piloting NHS Complaint standards, which set out in one place the ways in which the NHS should handle complaints, including the need for organisations to ensure people know how to escalate to the Ombudsman. The standards are included in the code of practice for independent providers, as developed by the Independent Sector Complaints Adjudication Service. The government has conducted a review of the data which confirmed that 94% of recorded patient episodes by the Private Health Information Network, were at providers who subscribed to the Independent Sector Complaints Adjudication Service. The Care Quality Commission has strengthened its guidance on this issue to	**Government response document:** Published 16 December 2021 **12-month government implementation progress update:** Published 15 December 2022 **NHS Complaint Standards** **Independent Sector Complaints Adjudication Service Code of Practice**: Published January 2022 **Updated Care Quality Commission Guidance**		Action 4.1 This recommendation has been implemented. CQC assesses all registered healthcare providers against the fundamental standard of 'complaints' (Regulation 16: receiving and acting on complaints) including ensuring information is available and accessible on how to complain. PHSO has been rolling out supporting materials for the NHS Complaints Standards across the NHS from end March 2023 - to improve how providers meet patient expectations when they make a complaint, including increasing awareness of independent resolution across the NHS. The Independent Sector Complaints Adjudication

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			clarify that there is an expectation that patients should have access to independent resolution, and that providers who do not provide such a mechanism must be able to show that patients are not disadvantaged by this.			Service (ISCAS) incorporated the Complaint Standards into its Code of Practice for Complaints Management and engaged independent providers in taking them up. All ISCAS subscribers were reminded of their responsibilities to incorporate the Complaint Standard Framework on renewal of their annual subscription in April 2023.
Improving patient safety	**P5**	Patient recall and ongoing care: All patients of Paterson should be recalled for review of their cases and provided with an ongoing treatment plan. Action 5.1: The University Hospitals Birmingham NHS Foundation Trust board should check that all patients of Paterson have been recalled, and to communicate with any who have not been seen. Action 5.2: Spire should check that all patients of Paterson have been recalled, and to communicate with any who have not been seen, and that they	Action 5.1: Accepted in full. By August 2020, University Hospitals Birmingham NHS Foundation Trust had contacted all known living patients of Ian Paterson. By the end of June 2021, the trust had ensured that all known former patients had had their care reviewed and that any outstanding concerns were addressed in a way that was determined by the patient. Action 5.2:	**Government response document:** Published 16 December 2021 **12-month government implementation progress update:** Published 15 December 2022		Action 5.1 By August 2020, UHB contacted all known living patients of Ian Paterson. By end June 2021, UHB had ensured that all known former patients had their care reviewed and that any outstanding concerns were addressed in a way that was determined by the patient. UHB continues to support any relatives of the

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		should check that they have been given an ongoing treatment plan in the same way that has been provided for patients in the NHS. (February 2020)	Accepted in full. By December 2020, Spire had proactively contacted all known living patients of Ian Paterson to check that their care had been fully reviewed, and that they were getting any ongoing support and treatment that they needed. Spire had reviewed the care of over two-thirds of the patients concerned. As of the 12-month implementation update, Spire had reviewed nearly all the patients affected.			deceased who make contact by providing a detailed review/report of the care their loved one received. Relatives are offered the chance to discuss the findings in a meeting (some have taken up this offer). Action 5.2 Spire reports that the reviews of nearly all the patients contacted since the Paterson inquiry report have been completed. To ensure that this exercise has not omitted any patients of Paterson, Spire continues to interrogate the complex legacy IT systems that pre-dated Spire's formation and takeover of Bupa hospitals. Spire will continue to contact any patients they identify as a result of this.

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Improving patient safety	**P6**	**Improving recall procedures:** Patients' experience of recall was generally inadequate, not patient-focussed, and lacked transparency. There were no national guidelines about recall at the time. Action 6.1: A national framework or protocol, with guidance, is developed about how recall of patients should be managed and communicated. This framework or protocol should specify that the process is centred around the patient's needs, provide advice on how recall decisions are made, and advise what resource is required and how this might be provided. This should apply to both the independent sector and the NHS. (February 2020)	Action 6.1: Accepted by the government in full. A national framework has been developed that outlines actions to be taken by organisations in both the NHS and the independent sector in the event of a patient recall. The National Patient Recall Framework was published in June 2022.	**Government response document:** Published 16 December 2021 **12-month government implementation progress update:** Published 15 December 2022 **National Patient Recall Framework:** Published 1 June 2022		Action 6.1 The National Quality Board (NQB) Recall Framework was published in 2022 to provide guidance on conducting a patient-centred recall process. CQC has incorporated the Recall Framework into its assessment process to ensure it is being used appropriately.
Improving the ability to raise complaints and concerns	**P7**	**Clinical indemnity:** The system of indemnity cover for the costs of claims and damages awarded to patients is discretionary and flawed. This requires improvement so patients are protected. Action 7.1: The Government should, as a matter of urgency, reform the current regulation of indemnity products for	Action 7.1: In 2018, the government launched a consultation on appropriate clinical negligence cover for regulated healthcare professionals, which was then extended to cover the issues raised by the Inquiry.	**Government response document:** Published 16 December 2021 **12-month government implementation**		Action 7.1 A summary of responses to the consultation was published on 15 December 2022. As highlighted in the 15/12/22 progress update, we have been assessing options such as

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		healthcare professionals, in light of the serious shortcomings identified by the Inquiry, and introduce a nationwide safety net to ensure patients are not disadvantaged. (February 2020)	The consultation was published on 15 December 2022. It was noted to be a challenging issue and 3 options were noted which are due to be explored through ongoing work.	**progress update:** Published 15 December 2022 **Consultation on appropriate clinical negligence cover:** Published 15 December 2022		safeguarding measures like a sector led Code of Practice. Based on wide ranging stakeholder feedback, we are also working on an education and training framework for the sector to improve healthcare professionals' knowledge of their clinical negligence cover and its importance for patients. In addition, we have commissioned an independent survey of healthcare professionals' indemnity arrangements. The report will be published shortly along with an update on progress.
Improving patient safety	**P8**	**Regulatory system:** Despite a large-scale regulatory system involving the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, and the Professional	Action 8.1: Accepted by the government in full.	**Government response document:** Published 16		Action 8.1 Actions include: CQC, NMC and GMC have launched new strategies with a focus on

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		Standards Authority for Health and Social Care, these organisations do not come together effectively to keep patients safe, nor is it accessible or understood by patients. Action 8.1: The Government should ensure that the current system of regulation and the collaboration of the regulators serves patient safety as the top priority, given the ineffectiveness of the system identified in this Inquiry. (February 2020)	The steps undertaken by the regulators as detailed above to encourage information-sharing and through provision of new guidance also contribute to this. The government proposes to provide a consistent regulatory framework for fitness to practise across all professional healthcare regulators. Our proposed changes will enable faster resolution of cases and deliver public protection more quickly. It also proposes to remove the 5-year rule, which was highlighted by the inquiry as a potential barrier to public protection. The removal of the 5-year rule will ensure that regulators are able to investigate concerns based on evidence, rather than an arbitrary time limit. This will form part of the Department of Health and Social Care consultations on legislation (below). The Department of Health and Social Care published a 2021 consultation which sets out proposals that address the issues raised in the Inquiry, including a proposal to place a duty to co-operate on all regulators. The Care Quality Commission has published the new single assessment	December 2021 **12-month government implementation progress update:** Published 15 December 2022 **Update from Care Quality Commission regarding new regulatory model** **Guidance from National Quality Board:** Published 21 January 2022 **Professional Standards Authority Report, ' Safer care for all - solutions from professional regulation and beyond'**: Published 6 September 2022 **Department of Health and Social Care consultation,**		collaboration and patient safety. CQC, NMC and GMC have also worked together on a shared data platform, initially for maternity services, to help share data and identify concerns. CQC has been rolling out a new regulatory model accompanied by a new single assessment framework. NQB has published National guidance on System Quality Groups, including how SQGs can share intelligence to identify quality concerns and risks in an ICS. This guidance explicitly includes IS providers within its scope. DHSC is also bringing forward a programme of reform through a series of statutory instruments from the end of 2023 to

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			framework and is in the process of developing a new regulatory model, with this due to be rolled out in 2023. The Department of Health and Social Care is working on changes to the Medical Profession (Responsible Officers) Regulations 2010 and expected the reformed regulations to be laid in spring or summer 2023. It was also preparing a series of statutory instruments to achieve a programme of reform to modernise the regulatory system for healthcare professionals, including a duty to co-operate. The first statutory instrument was due to be introduced at the end of 2023. These documents are still outstanding; there was a consultation in 2021 on regulating healthcare professionals which concluded in February 2023, and there is a further consultation on the draft legislation which is in progress, with responses being closed in May 2023.	**'Regulating healthcare professionals, protecting the public':** Published 24 March 2021; updated 17 February 2023 **Department of Health and Social Care consultation on draft legislation:** Published 17 February 2023		modernise the regulatory system for healthcare professionals, including a consistent duty to co-operate for all healthcare regulators. DHSC is working on changes to the Medical Profession (Responsible Officers) Regulations 2010 and is aiming to lay the reformed regulations in Summer 2024.

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Improving patient safety	**P9**	**Investigating healthcare professionals' practice and behaviour:** There were concerns about an HR process being used to investigate Paterson despite the concerns being around his clinical practice. He was not suspended as early as he should have been and the concerns were not raised early enough by the NHS Trust with Spire Hospitals. Action 9.1a: When a hospital investigates a healthcare professional's behaviour, including the use of an HR process, any perceived risk to patient safety should result in the suspension of that healthcare professional. Action 9.1b: If the healthcare professional also works at another provider, any concerns about them should be communicated to that provider. (February 2020)	Action 9.1: Not accepted by the government. *"We agree that exclusions and restriction of practice can be necessary and, in some cases, immediate exclusion is an appropriate response while an investigation is ongoing. However, we do not believe it would be fair or proportionate to impose a blanket rule to exclude practitioners in such cases.* *Such a step may inadvertently cause a chilling effect, dissuading healthcare professionals from raising concerns, and negatively impacting patient safety. It is vital that investigations are robust and conducted in a timely manner.* *Guidance has been put in place to ensure that concerns are taken seriously, appropriate action taken and that robust investigation processes are implemented, and that clarity on when to exclude a healthcare professional is provided.*" – Government response document, 16 December 2021. Action 9.1b:	**Government response document:** Published 16 December 2021 **12-month government implementation progress update:** Published 15 December 2022		Action 9.1.a The government set out that the underlying goal of this recommendation could be met. Action 9b The government agrees that where a provider has evidence that an individual is shown to be acting in an unsafe way, they should share concerns about that individual's practice with other providers who they work with, in a way that complies with GDPR obligations. Regulators have taken important actions to make it easier for people and organisations to share information regarding patient safety risks e.g. GMC is clear in its guidance that patient safety is paramount when deciding whether to share

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			Accepted in principle by the government: "The government agrees that, where patient safety is at risk, information should be shared with other providers. However, there must be an element of judgement by providers as they will be taking on responsibility to ensure that this information is appropriate and accurate." To be considered further by the Department of Health and Social Care in its review of the Medical Profession (Responsible Officers) Regulations 2010 (revised in 2013), awaited.			information about doctors and that this should occur in a timely manner. DHSC is working on changes to the Medical Profession (Responsible Officers) Regulations 2010 to ensure they are fit for use in the changing healthcare landscape which includes considering how best to strengthen information-sharing systems around professionals as part of these reforms. Reformed regulations are expected to be laid in 2024. The government has stated that investigations when concerns are raised about medical professionals should be conducted in an appropriate, timely and thorough way. In doing this, Responsible Officers must ensure that local

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						processes are in place for raising and acting on concerns about doctors, with issues escalated to the GMC as appropriate. NHS Resolution provides expertise to help foster a fair and compassionate approach, and a learning culture when supporting employing and/or contracting organisations and practitioners when concerns are raised about an individual's practice. NHSR encourages organisations and practitioners to use this service as early as possible. NHSR has also launched new guidance on making decisions relating to exclusions, which includes the need to communicate these decisions to other providers who work with the professional in question.

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Improving the ability to raise complaints and concerns						
Improving patient safety	**P10**	**Corporate accountability:** There is a gap between the situation in the NHS, where consultants are employees and the NHS hospital therefore accepts liability when things go wrong; and in the independent sector, where most consultants are self-employed, and there are questions regarding hospitals' or providers' legal liability for the actions of consultants. Patients felt they did not receive accountability in the form of meaningful apologies. Action 10.1: The Government addresses, as a matter of urgency, this gap in responsibility and liability. Action 10.2: When things go wrong, boards should apologise at the earliest stage of investigation and not hold back from doing so for fear of the consequences in relation to their liability. (February 2020)	Action 10.1: Accepted in principle. There has been a refresh of the Medical Practitioners Assurance Framework (originally published in 2019). The new report, published September 2022, makes clear that independent sector providers must take responsibility for the quality of care provided in their facilities. This framework is taken into account by the Care Quality Commission as appropriate. In April 2022, NHS Resolution published a suite of resources to support decisions relating to the exclusion of professionals. Issues relating to liability have been dealt with in Recommendation/Principle 7. Action 10.2: Accepted in full.	**Government response document:** Published 16 December 2021 **12-month government implementation progress update:** Published 15 December 2022 **Medical Practitioners Assurance Framework Refresh**: Published September 2022 **NHS Resolution Resources** **Care Quality Commission Guidance on the duty**		Action 10.2 This recommendation has been implemented. CQC has produced guidance on the statutory Duty of Candour which explicitly states that apologising is "a crucial part of the duty of candour" that does not amount to an admission of liability. Compliance with the statutory Duty of Candour is integral to the CQC's assessment process. NHSR has launched a new animation on the Duty of Candour, which underlines that apologising is always the right thing to do. NHSR continues to provide resources and engagement on both the need to provide apologies

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			New Care Quality Commission guidance has been produced on the statutory duty of candour, which explicitly states that apologising is "a crucial part of the duty of candour" that does not amount to an admission of liability. Compliance with this statutory duty is part of the Care Quality Commission assessment process.	**of candour**: Published 22 December 2022		when appropriate, and on how to do so effectively.
Improving patient safety	**P11**	**Adoption of the Inquiry's recommendations in the independent sector:** The independent sector has a different governance model (despite sharing a regulatory system with the NHS) and it is therefore not possible for the Government to require the independent sector to implement all the recommendations it accepts. Good practice is often voluntary in the independent sector. Action 11.1: If the Government accepts any of the recommendations concerned, it should make arrangements to ensure that these are to be applicable across the whole of the independent sector's workload (i.e. private, insured and NHS-funded) if independent sector providers are to be	Action 11.1: Not accepted by the government. This remained the case at the 12-month review mark and was due to be reviewed further in another 12 months.	**Government response document:** Published 16 December 2021 **12-month government implementation progress update:** Published 15 December 2022		Not implemented as per government response. No further action has been taken in relation to this recommendation.

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		able to qualify for NHS-contracted work. (February 2020)				

27 OCKENDEN INDEPENDENT REVIEW OF MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

27.1 Introduction

In response to concerns from bereaved families about maternity services at Shrewsbury and Telford Hospital NHS Trust, an independent review was set up in 2017 and chaired by Donna Ockenden. Its original scope was to cover the cases of 23 families but since it began, many more families have reported concerns. As a result, early conclusions were published in an initial report dated 10 December 2020 (the "**First Ockenden Report**"). The report can be viewed online.

The Government accepted all of the recommendations from this first report and the NHS was tasked with taking them forward. On 30 March 2022, a further (final) report was published (the "**Second Ockenden Report**") which considered the experiences of almost 1,500 families, from 2000 to 2019. The report can also be viewed online.

All of the recommendations in both the First and Second Ockenden Reports were accepted by local trust, NHS England, and the Department of Health and Social Care. On 30 March 2022 the Secretary of State for Health and Social Care reported that he had asked NHS England to write to all trusts that provide maternity services instructing them to assess themselves against the actions in the Reports and that NHS England would be setting out a renewed delivery plan that reflects the recommendations.

27.2 Ockenden Independent Review of Maternity Services: Tables of Recommendations

(a) The First Ockenden Report

Ockenden Independent Review of Maternity Services: First Report						
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**	**DHSC Comments**
Immediate and Essential Actions from the First Ockenden Report						
Improving patient safety	**IEA 1 (1st)**	**10 December 2020: Enhanced safety** *Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks.* *Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.* • Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on Local Maternity System agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum	All noted in noted in Trust Action Plan as delivered as at 9 April 2024 except for the action "*A Local Maternity System cannot function as one maternity service only".* The status commentary described the action as "*descoped*" at the March 2024 Maternity Transformation Assurance Committee with work continuing with the Local Maternity System to deliver the action. The commentary noted that significant work remained to facilitate completion and the timeline could not yet be determined.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan Board of Directors' Meeting (August 2023) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital		To see update in Jan 24 Trust Board papers on the action "*An LMS cannot function as one maternity service only".* Action to remain 'off track' following the Jan-24 MTAC. Nevertheless, progress has been made by the Division and ICB colleagues, with the assurance ('green') evidence strengthened and agreed by all parties. Another exception report will be brought to the committee once timeframes are

Ockenden Independent Review of Maternity Services: First Report						
		fetal death, maternal death, neonatal brain injury and neonatal death. • Local maternity System must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them. • A Local Maternity System cannot function as one maternity service only. • The Local maternity System Chair must hold Clinical Commissioning Group Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda. • All maternity serous incident reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the Local Maternity System for scrutiny, oversight and transparency. This must be done at least every 3 months.		NHS Trust, April 2024		established for the action to move back 'on track'.
Improving the ability to raise complaints and concerns	**IEA 2 (1st)**	**10 December 2020: Listening to women and families** *Maternity services must ensure that women and their families are listened to with their voices heard.* • Trusts must create an independent senior advocate role which reports to	In the April 2024 Action Plan, actions 2.1 and 2.2 were noted as not yet delivered but on track. The commentary notes that both had been considered at the March 2024 Maternity Transformation Assurance Committee, where	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020)		There are updates on this IEA in the January Board papers: Actions 2.1 and 2.2 have both been flagged at 'at risk' because advocate

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		both the Trust and the Local maternity System Boards. • The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. • Each Trust Board must identify a nonexecutive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions. • Care Quality Commission inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.	delivery deadline of August 2024 and assurance deadline of December 2024 had been accepted. Action 2.4, relating to Care Quality Commission inspections was recorded as "*descoped*" but also "*delivered, not yet evidenced*".	First Ockendon Report Action Plan Board of Directors' Meeting (August 2023) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		role has resigned from role;
	IEA 3 (1st)	**10 December 2020: Staff training and working together** *Staff who work together must train together.* • Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be	All noted in Trust Action Plan as completed as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020)		

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		externally validated through the Local maternity System, 3 times a year. • Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. • Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.		First Ockendon Report Action Plan		
	IEA 4 (1st)	**10 December 2020: Managing complex pregnancy** *There must be robust pathways in place for managing women with complex pregnancies.* *Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.* • Women with complex pregnancies must have a named consultant lead. • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team. • The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national	All noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		

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		priority to allow early discussion of complex maternity cases with expert clinicians. • This must also include regional integration of maternal mental health services.				
	IEA 5 (1st)	**10 December 2020: Risk assessment throughout pregnancy** *Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.* • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional. • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	All noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		
	IEA 6 (1st)	**10 December 2020: Monitoring fetal wellbeing** *All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.* • The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:	All noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		

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		• Improving the practice of monitoring fetal wellbeing - Consolidating existing knowledge of monitoring fetal wellbeing • Keeping abreast of developments in the field • Raising the profile of fetal wellbeing monitoring • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on he review of cases of adverse outcome involving poor FHR interpretation and practice. • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.				
	IEA 7 (1st)	**10 December 2020: Informed consent** *All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and*	All noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust		

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		mode of birth, including maternal choice for caesarean delivery. • All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care • Women must be enabled to participate equally in all decision making processes and to make informed choices about their care. • Women's choices following a shared and informed decision making process must be respected.		(December 2020) First Ockendon Report Action Plan		
Local Actions for Learning from the First Ockenden Report 10 December 2020: Maternity Care						
	LafL 8 (1st)	A thorough risk assessment must take place at the booking appointment and at every antenatal appointment to ensure that the plan of care remains appropriate. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020)		

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				First Ockendon Report Action Plan		
	LafL 9 (1st)	All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision making processes and make informed choices about their care. Women's choices following a shared decision making process must be respected. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		
	LafL 10 (1st)	The maternity service at The Shrewsbury and Telford Hospital NHS Trust must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		

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Improving patient safety	**LafL 11 (1st)**	These leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 (2019) and subsequent national guidelines. This additionally must include regional peer reviewed learning and assessment. These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		
	LafL 12 (1st)	Staff must use NICE Guidance (2017) on fetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		
Improving NHS culture and governance	**LafL 13 (1st)**	The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust		

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				(December 2020) First Ockendon Report Action Plan		
Improving patient safety	**LafL 14 (1st)**	The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		
	LafL 15 (1st)	Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		

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Improving patient safety	**LafL 16 (1st)**	There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		
	LafL 17 (1st)	Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		
	LafL 18 (1st)	The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust		

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		and must continue throughout any additional procedure in labour. (December 2020)		(December 2020) First Ockendon Report Action Plan		
Improving NHS culture and governance	**LafL 19 (1st)**	The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		
	LafL 20 (1st)	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		

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10 December 2020: Maternal deaths						
Improving patient safety	**LafL 21 (1st)**	The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		
	LafL 22 (1st)	Women with pre-existing medical comorbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy. (December 2020)	Noted in Trust Action Plan as delivered but not yet evidenced as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		
Improving patient safety	**LafL 23 (1st)**	There must be a named consultant with demonstrated expertise with overall responsibility for the care of high risk women during pregnancy, labour and birth and the post-natal period. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust		

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				(December 2020) First Ockendon Report Action Plan		
10 December 2020: Obstetric anaesthesia						
	LafL 24 (1st)	Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockendon Report Action Plan		
	LafL 25 (1st)	Obstetric anaesthetists must be proactive and make positive contributions to team learning and the improvement of clinical standards. Where there is apparent disengagement from the maternity service the obstetric anaesthetists themselves must insist they are involved and not remain on the periphery, as the review team have observed in a number of cases reviewed. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockenden Report Action		

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				Plan (Progress as at 12.09.23)		
	LafL 26 (1st)	Obstetric anaesthetists and departments of anaesthesia must regularly review their current clinical guidelines to ensure they meet best practice standards in line with the national and local guidelines published by the Royal College of Anaesthetists and the Obstetric Anaesthetists' Association. Adherence to these by all obstetric anaesthetic staff working on labour ward and elsewhere, must be regularly audited. Any changes to clinical guidelines must be communicated and necessary training be provided to the midwifery and obstetric teams. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 27 (1st)	Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service with support from the Trust executive. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockenden Report Action Plan (Progress as at 12.09.23)		

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	LafL 28 (1st)	The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published Royal College of Anaesthetists 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice'. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 29 (1st)	The Trust must ensure appropriately trained and appropriately senior/experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 30 (1st)	The service must ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust		

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				(December 2020) First Ockenden Report Action Plan (Progress as at 12.09.23)		
10 December 2020: Neonatal service						
Improving patient safety	**LafL 31 (1st)**	Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockenden Report Action Plan (Progress as at 12.09.23)		To see: https://www.sath.nhs.uk/wp-content/uploads/2024/02/021.24a-BoD-PUBLIC-February-2024_Appendix-One_-Ockenden-Report-Action-Plan-at-9-January-2024_FINAL.pdf Exception report accepted at the Aug-23 MTAC for assurance deadline to be extended to Jan-24.

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Improving patient safety	**LafL 32 (1st)**	There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving patient safety	**LafL 33 (1st)**	The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit. (December 2020)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (December 2020) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving patient safety	**LafL 34 (1st)**	There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and advanced neonatal nurse practitioners must have the opportunity of regular observational	Recorded as "*not yet delivered*" but "*on track*" in the April 2024 action plan. The commentary noted that an exception report at the April 2024 Maternity Transformation Assurance Committee had been accepted, for a deadline extension for	Maternity Services at the Shrewsbury and Telford Hospital NHS Trust		To see update here, which is copied below:

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		attachments at another neonatal intensive care unit. (December 2020)	delivery evidence to May 2024 and assurance evidence to May 2025, to allow time to solve staffing issues for advanced neonatal nurse practitioners to be released to visit another neonatal intensive care unit for educational purposes.	(December 2020) First Ockenden Report Action Plan (Progress as at 12.09.23) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		https://www.sath.nhs.uk/wp-content/uploads/2024/02/021.24a-BoD-PUBLIC-February-2024_Appendix-One_-Ockenden-Report-Action-Plan-at-9-January-2024_FINAL.pdf Exception report accepted at the May-23 MTAC requesting deadline extensions for delivery evidence to Dec-23 and assurance evidence to Mar-24, allowing time to solve staffing issues for ANNPs to be released to visit another NICU for educational purposes.

(b) The Second Ockenden Report

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Immediate and Essential Actions from the Second Ockenden Report (30 March 2022)						**DHSC Comments**
Improving NHS culture and governance	**IEA 1 (2nd)**	**Workforce planning and sustainability** **30 March 2022: Financing a safe maternity workforce** *The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.* • The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England. • Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the Local Maternity and Neonatal Systems. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational Clinical Negligence Scheme for Trusts and Care Quality Commission requirements. • Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including	All noted in Trust Action Plan as completed as at 9 April 2024 except as follows: IEA 1.1, 1.4 and 1.11 noted to be not yet delivered and descoped as the actions were dependent on the work of national bodies. IEA 1.2 was recorded as "*delivered, not yet evidence*" and "*at risk* due to the unlikelihood of meeting the March 24 deadline". The minimum staffing action had been outlined in the Ockenden Business Case and was going through governance process. IEA 1.7 was also recorded as "*delivered, not yet evidenced*" and "*at risk*. While the education programme had been approved nationally, it was unlikely all staff would complete the relevant education module by the March 2024 deadline. The Secretary of State for Health and Social Care stated on 30 March 2022 that, since the First Ockenden Report, £95 million of funding had been made available for maternity services across England to boost the maternity workforce, and to fund programmes for training, development and leadership. He also stated that the NHS had, in March 2022, announced a £127 million funding boost for maternity	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23) Board of Directors' Meeting (August 2023) Ockenden report: statement by the Secretary of State for Health and Social Care (March 2022) Final Ockenden Report Action Plan, Shrewsbury		Since 2021, NHS England has invested an additional £165m/year to improve maternity and neonatal care. This will rise to an additional £186m/year from 2024/25 with part year effect in 2023/24. This national investment provides for an increase in midwifery establishment by 1,200 FTE and obstetric consultant establishment by 100 FTE; additional neonatology consultant capacity will be achieved through the funding made available in August 2023.

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		sickness, mandatory training, annual leave and maternity leave. • The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHS England, the Royal College of Obstetrics and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health. **30 March 2022: Training** *We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.* • All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the Royal College of Midwives (2017) position statement for this. • All newly qualified midwives must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	services across England to bolster the maternity workforce and to fund programmes to strengthen leadership, retention and capital for neonatal maternity care.	and Telford Hospital NHS Trust, April 2024		Source: NHS England » Update from the Maternity and Neonatal Programme

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		• All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce. • All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development. • All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one high dependency unit trained midwife on each shift, 24/7. • All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience. • The review team acknowledges the progress around the creation of Maternal Medicine				

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		Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.				
Improving patient safety	**IEA 2 (2nd)**	**30 March 2022: Safe staffing** *All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.* • When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and Local Maternity System. • In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level. • All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification. • All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Care unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the	All noted in Trust Action Plan as completed, evidenced and assured as at 9 April 2024.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		

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		safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that Midwifery Continuity of Carer models place on maternity services already under significant strain. • The reinstatement of Midwifery Continuity of Carer should be withheld until robust evidence is available to support its reintroduction • The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change. • All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings. • Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles. • All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication. • All trusts should follow the latest Royal College of Obstetricians and Gynaecologists guidance on managements of locums. The Royal College of Obstetricians and Gynaecologists encourages the use of internal locums and has developed practical guidance with NHS England on the management				

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		of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.				
Improving the ability to raise complaints and concerns	**IEA 3 (2nd)**	**30 March 2022: Escalation and accountability** *Staff must be able to escalate concerns if necessary* *There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.* *If not resident there must be clear guidelines for when a consultant obstetrician should attend.* • All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.	All noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23) Final Ockenden Report Action Plan, Shrewsbury and Telford		

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Improving NHS culture and governance		• When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role. • Trusts should aim to increase resident consultant obstetrician presence where this is achievable. • There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit. • There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.		Hospital NHS Trust, April 2024		
Improving NHS culture and governance	**IEA 4 (2nd)**	**30 March 2022: Clinical governance - Leadership** *Trust boards must have oversight of the quality and performance of their maternity services.* *In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.* • Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans. • All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously	All noted in Trust Action Plan as completed, evidenced and assured as at 9 April 2024, save for IEA 4.3. IEA 4.3 was recorded as "*not yet delivered*" and "*at risk*" as the March 2024 deadline would not be met due to delivery being linked to approval of further funding. The Secretary of State for Health and Social Care stated on 30 March 2022 that the Department would create a working group independent of the Maternity Transformation Programme with joint leadership from the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23) Ockenden report: statement by the Secretary of State for Health and		

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		done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board. • Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services. • All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities. • All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement. • All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research. • All maternity services must ensure they have midwifery and obstetric co-leads for audits.		Social Care (March 2022) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		
Improving NHS culture and governance	**IEA 5 (2nd)**	**30 March 2022: Clinical governance – incident investigation and complaints** *Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.* • All maternity governance teams must ensure the language used in investigation reports is easy to	All noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023. The Secretary of State for Health and Social Care stated on 30 March 2022 that the Department would create a working group independent of the Maternity Transformation Programme with joint leadership from the Royal	Final Ockendon Report (March 2022) First Ockenden Report Action		

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		understand for families, for example ensuring any medical terms are explained in lay terms. • Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan. • Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred. • Change in practice arising from a serious incident investigation must be seen within 6 months after the incident occurred. • All trusts must ensure that complaints which meet SI threshold must be investigated as such. • All maternity services must involve service users (ideally via their Maternity Voices Partnership) in developing complaints response processes that are caring and transparent. • Complaints themes and trends must be monitored by the maternity governance team.	College of Midwives and the Royal College of Obstetricians and Gynaecologists. The Secretary of State also announced in January 2022 plans to create a special health authority to continue the Maternity Investigation Programme that was currently run by the Healthcare Safety Investigation Branch. This is now run by the Care Quality Commission.	Plan (Progress as at 12.09.23) Ockenden report: statement by the Secretary of State for Health and Social Care (March 2022		
	IEA 6 (2nd)	**30 March 2022: Learning from maternal deaths** *Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.* *In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.*	All noted in Trust Action Plan as either delivered or on track as at 12 September 2023 except for the action "*NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death*". The Trust Board Minutes of 10 August 2023 and Action Plan (as at 2 September 2023) noted that this action was 'not yet delivered' because it had been 'de-scoped' since it was an action with	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		

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		• NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death. • This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required. • Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the Local Maternity System.	external dependencies and require national action.	Board of Directors' Meeting (August 2023)		
Improving NHS culture and governance	**IEA 7 (2nd)**	**30 March 2022: Multidisciplinary training** *Staff who work together must train together.* *Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.* *Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training.* • All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored. • Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	All noted in Trust Action Plan as completed, evidenced and assured as at 9 April 2024.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS		

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		• All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the Local Maternity System. • There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient. • There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care. • Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills. • Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.		Trust, April 2024		
	IEA 8 (2nd)	**30 March 2022: Complex antenatal care** *Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.* *Trusts must provide services for women with multiple pregnancy in line with national guidance.*	All noted in Trust Action Plan as completed, evidence and assured as at 9 April 2024 save for IEA 8.1. IEA 8.1 was recorded as '*not yet delivered"* and "*at* risk" as the final March 2024 deadline would not be met. This was because delivery of	Final Ockendon Report (March 2022) First Ockenden Report Action		

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		Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy. • Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have. • Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019. • NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes. • When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records. • Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment.	actions was linked to approval of further funding.	Plan (Progress as at 12.09.23) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		

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		Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).				
Improving patient safety	**IEA 9 (2nd)**	**30 March 2022: Preterm birth** *The Local Maternity and Neonatal System, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.* *Trusts must implement NHS Saving Babies Lives Version 2 (2019).* • Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability. • Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered. • Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability. • There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	All noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		

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	IEA 10 (2nd)	**30 March 2022: Labour and birth** *Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.* *Centralised CTG monitoring systems should be mandatory in obstetric units.* • All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made • Midwifery-led units must complete yearly operational risk assessments. • Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan. • It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust. • Maternity units must have pathways for induction of labour). Trusts need a mechanism to clearly	All noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		

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		describe safe pathways for induction of labour if delays occur due to high activity or short staffing. • Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.				
	IEA 11 (2nd)	**30 March 2022: Obstetric anaesthesia** *In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.* *Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.* *Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.* • Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic	All noted in Trust Action Plan as either delivered or on track as at 9 April 2024 save for IEA 11.1 and 11.4. IEA 11.1 said to be moved in November 2023 from "*on track*" to "*at risk*" as March 2024 deadline would not be met. This was said to be because delivery of further action was linked to approval of further funding. IEA 11.4 was recorded as "*descoped*" due to the action being fully dependent on national bodies (Royal College of Anaesthetists) obtaining resources.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23) Board of Directors' Meeting (August 2023) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		

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		interventions, and significant failure of labour analgesia. • Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences. • All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC. • Resources must be General Medical Council available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance. • Obstetric anaesthesia staffing guidance to include: • The role of consultants, specialty and specialist doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave. • The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.				

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		• The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments. • Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.				
	IEA 12 (2nd)	**30 March 2022: Postnatal care** *Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.* *Postnatal wards must be adequately staffed at all times.* • All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a nonmaternity ward. • Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum. • Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary. • Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	In the Trust Action Plan dated 9 April 2024, IEA 12.1 and 12.4 were recorded as completed. IEA 12.2 and 12.3 were noted as "*delivered, not yet evidence*" and "*at risk*". In respect of both, this was stated to be due to the unlikelihood of the action meeting the March 2024 deadline due to funding.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		

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Improving NHS culture and governance	**IEA 13 (2nd)**	**30 March 2022: Bereavement care** *Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.* • Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday. • All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations. • All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome. • Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	All noted in Trust Action Plan as completed, evidenced and assured as at 9 April 2024.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		
Improving patient safety	**IEA 14 (2nd)**	**30 March 2022: Neonatal care** *There must be clear pathways of care for provision of neonatal care.* *This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to*	In the Trust Action Plan dated April 2024, all noted as completed save for IEA 14.4 and 14.5. IEA 14.4 was recorded as "*descoped*" and "*not yet delivered*" as delivery sat with the Neonatal Delivery Network. The Trust said it would	Final Ockendon Report (March 2022) First Ockenden		The implementation of the NCCR actions is continuing with progress being monitored nationally via the

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		expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace. • Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided. • Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems quarterly. • Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite neonatal intensive care unit. • Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, advanced neonatal nurse practitioner and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	continue to work on enabling rotation of neonatal staff within other units. IEA 14.5 was recorded as "*descoped*" and "*delivered, not yet evidenced*" as the Trust had been providing the Network with requested reports and action was now in the hands of the Network to progress.	Report Action Plan (Progress as at 12.09.23) Board of Directors' Meeting (August 2023) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		Neonatal Implementation Board. There has been investment (£45m) to increase and realign cot capacity. NHS England » Update from the Maternity and Neonatal Programme

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		• Each network must report to commissioners annually what measures are in place to prevent units from working in isolation. • Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required. • Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support Course must consider highlighting this treatment point more clearly in the Newborn Life Support algorithm. • Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or advanced neonatal nurse practitioners) and nurses are available in every type of neonatal unit (neonatal intensive care unit, local neonatal unit and special care baby unit) to deliver safe care 24/7 in line with national service specifications.				

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Improving NHS culture and governance	**IEA 15 (2nd)**	**30 March 2022: Supporting families** *Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision.* *Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care.* • There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate. • Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences. • Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.	All noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Local Actions for Learning (LafL) for the Trust from the Second Report (30 March 2022)						
Clinical Governance **30 March 2022: Improving management of patient safety incidents**						

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Improving patient safety	**LafL 1 (2nd)**	Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework. (March 2022)	Trust Board Minutes of 10 August 2023 noted that this action was 'not yet delivered' because it had been 'de-scoped' since it was an action with external dependencies and requires national action. The minutes and the Action Plan (as at 12 September 2023) note the Trust was 'awaiting national staged roll out of new processes' and 'new Patient Safety Incident Response Framework'. The April 2024 action plan recorded the action as back in scope and on track, with evidence for assurance to be presented in April 2024.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23) Board of Directors' Meeting (August 2023) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		
Improving the ability to raise complaints and concerns	**LafL 2 (2nd)**	The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations. (March 2022)	Noted in Trust Action Plan as 'delivered' but 'not yet evidenced', though progress 'on track'. In the April 2014 Action Plan, the Trust said that the deadline for assurance of this action had been extended to June 2024,	Final Ockendon Report (March 2022) First Ockenden		

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				Report Action Plan (Progress as at 12.09.23) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		
Improving the ability to raise complaints and concerns	**LafL 3 (2nd)**	All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving the ability to raise complaints and concerns	**LafL 4 (2nd)**	The use of high risk care reviews to investigate incidents must be abolished and correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022)		

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				First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving the ability to raise complaints and concerns	**LafL 5 (2nd)**	Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving the ability to raise complaints and concerns	**LafL 6 (2nd)**	All serious incidents must be completed within the timeframe set out in the serious incident framework. Any serious incidents not meeting this timeline should be escalated to the Trust Board. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving NHS culture	**LafL 7 (2nd)**	All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy.	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon		

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and governance		These training courses must commence within the next 12 months. (March 2022)		Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving NHS culture and governance	**LafL 8 (2nd)**	The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in Healthcare Safety Investigation Branch investigation reports. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving NHS culture and governance	**LafL 9 (2nd)**	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
30 March 2022: Patient and family involvement						

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Improving the ability to raise complaints and concerns	**LafL 10 (2nd)**	The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving the ability to raise complaints and concerns	**LafL 11 (2nd)**	All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving the ability to raise complaints and concerns	**LafL 12 (2nd)**	The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations. (March 2022)	Recorded in the April 2024 Trust Action Plan as competed, evidenced and assured.	Final Ockendon Report (March 2022) Final Ockenden Report Action Plan, Shrewsbury		

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				and Telford Hospital NHS Trust, April 2024		
30 March 2022: Support for staff						
Improving the ability to raise complaints and concerns	**LafL 13 (2nd)**	There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving the ability to raise complaints and concerns	**LafL 14 (2nd)**	The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
30 March 2022: Improving complaints handling						

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Improving the ability to raise complaints and concerns	**LafL 15 (2nd)**	Complaint responses should be empathetic and kind in their nature. The local Maternity Voices Partnership must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving the ability to raise complaints and concerns	**LafL 16 (2nd)**	Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the Maternity Voices Partnership. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving the ability to raise complaints and concerns	**LafL 17 (2nd)**	All staff involved in preparing complaint responses must receive training in complaints handling. (March 2022)	Noted in Trust Action Plan as 'delivered' but 'not yet evidenced', though progress 'on track'.	Final Ockendon Report (March 2022) First Ockenden Report Action		

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				Plan (Progress as at 12.09.23)		
30 March 2022: Improving audit process						
	LafL 18 (2nd)	There must be midwifery and obstetric co-leads for audits. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 19 (2nd)	Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 20 (2nd)	Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022)		

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				First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 21 (2nd)	Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving the ability to raise complaints and concerns	**LafL 21 *[sic]* (2nd)**	Matters arising from clinical incidents must contribute to the annual audit plan. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
30 March 2022: Improving guidelines process						
	LafL 22 (2nd)	There must be midwifery and obstetric co-leads for developing guidelines. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden		

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				Report Action Plan (Progress as at 12.09.23)		
	LafL 23 (2nd)	A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
		30 March 2022: Leadership and oversight				
Regulation and oversight of NHS managers	**LafL 24 (2nd)**	The Trust Board must review the progress of the maternity improvement and transformation plan every month. (March 2022)	Noted in January 2024 Action Plan as completed, evidenced and assured.	Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		Noted in Trust Action plan as Action complete - evidenced and assured. 021.24a-BoD-PUBLIC-February-2024_Appendix-One_-Ockenden-Report-Action-Plan-at-9-January-2024_FINAL.pdf (sath.nhs.uk)

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Regulation and oversight of NHS managers	**LafL 25 (2nd)**	The maternity services senior leadership team must use appreciative inquiry to complete the National Maternity Self-Assessment Tool published in July 2021, to benchmark their services and governance structures against national standards and best practice guidance. They must provide a comprehensive report of their self-assessment, including any remedial plans which must be shared with the Trust Board. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Regulation and oversight of NHS managers **Improving the ability to raise complaints and concerns**	**LafL 26 (2nd)**	The Director of Midwifery must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Antenatal care **30 March 2022: Care of vulnerable and high risk women**						
	LafL 27 (2nd)	The Trust must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022)		

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				First Ockenden Report Action Plan (Progress as at 12.09.23)		
30 March 2022: Fetal Growth Assessment and Management						
	LafL 28 (2nd)	The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height measurements and audit of the documentation of it, at least annually. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		
	LafL 29 (2nd)	Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed. These recommendations are part of the Saving Babies Lives Toolkit (2015 and 2019). (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	First Ockenden Report Action Plan (Progress as at 12.09.23)		
30 March 2022: Fetal medicine care						
	LafL 30 (2nd)	The Trust must ensure parents receive appropriate information in all cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases. (March 2022)	Recorded in the Trust Action Plan as completed, evidenced and assured as at 9 April 2024.	Final Ockenden Report Action Plan, Shrewsbury and Telford		Noted as delivered, but not yet evidenced. 021.24a-BoD-PUBLIC-February-

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				Hospital NHS Trust, April 2024		2024_Appendix-One_-Ockenden-Report-Action-Plan-at-9-January-2024_FINAL.pdf (sath.nhs.uk)
	LafL 31 (2nd)	Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records. (March 2022)	Noted in Trust Action Plan as completed, evidenced and assured as at 9 April 2024.	Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		Noted as delivered, but not yet evidenced. 021.24a-BoD-PUBLIC-February-2024_Appendix-One_-Ockenden-Report-Action-Plan-at-9-January-2024_FINAL.pdf (sath.nhs.uk)
30 March 2022: Diabetes care						
	LafL 32 (2nd)	The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave. (March 2022)	Recorded in Trust Action Plan dated April 2024 to be at "*at risk*" as the final March 2024 deadline would not be met because delivery was linked to approval of further funding.	Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS		To see Trust Board papers. Progress status changed to 'at risk'. 021.24a-BoD-PUBLIC-February-

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				Trust, April 2024		2024_Appendix-One_-Ockenden-Report-Action-Plan-at-9-January-2024_FINAL.pdf (sath.nhs.uk)
30 March 2022: Hypertension						
	LafL 33 (2nd)	Staff working in maternity care at the Trust must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
30 March 2022: Consultant obstetric ward rounds and clinical review						
	LafL 34 (2nd)	All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHS England 2017). These consultant reviews must occur with a clearly documented plan recorded in the maternity records. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		

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	LafL 35 (2nd))	All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 36 (2nd)	The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR to enable all staff to escalate and communicate their concerns. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
30 March 2022: Escalation of concerns						
Improving the ability to raise complaints and concerns	**LafL 37 (2nd)**	The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action		

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				Plan (Progress as at 12.09.23)		
	LafL 38 (2nd)	The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward. (March 2022)	Noted in Trust Action Plan as 'not yet delivered' but progress 'on track'.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		Noted as delivered but not yet evidenced. 021.24a-BoD-PUBLIC-February-2024_Appendix-One_-Ockenden-Report-Action-Plan-at-9-January-2024_FINAL.pdf (sath.nhs.uk)
	LafL 39 (2nd)	The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts and Saving Babies Lives. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Intrapartum care 30 March 2022: Multidisciplinary working						

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	LafL 40 (2nd)	The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 41 (2nd)	The labour ward coordinator at the Trust must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 42 (2nd)	There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action		

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				Plan (Progress as at 12.09.23)		
	LafL 43 (2nd)	Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership. (March 2022)	Noted in Trust Action Plan as 'delivered' but 'not yet evidenced', though progress 'on track'.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
Improving NHS culture and governance	**LafL 44 (2nd)**	All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out when they have concerns about safe care. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
30 March 2022: Fetal assessment and monitoring						
	LafL 45 (2nd)	Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022)		

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				First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 46 (2nd)	The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 46 *[sic]* (2nd)	Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
30 March 2022: Specific to midwifery-led units and out-of-hospital births						

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	LafL 47 (2nd)	Midwifery-led units must complete yearly operational risk assessments. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 48 (2nd)	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 49 (2nd report)	It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action		

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				Plan (Progress as at 12.09.23)		
30 March 2022: Maternal deaths						
	LafL 50 (2nd)	In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the Local Maternity System. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
30 March 2022: Obstetric anaesthesia						
	LafL 51 (2nd)	The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with Guidelines for the Provision of Anaesthetic Services at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 52 (2nd)	The Trust's executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal	Noted in Trust Action Plan dated April 2024 as "*not yet delivered*" and "*at risk*" as final March	Final Ockenden Report Action		Noted as not yet delivered and also at risk.

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		Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust's services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service. (March 2022)	2024 deadline would not be met. This was because delivery was linked to approval of further funding.	Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		021.24a-BoD-PUBLIC-February-2024_Appendix-One_-Ockenden-Report-Action-Plan-at-9-January-2024_FINAL.pdf (sath.nhs.uk)
	LafL 53 (2nd)	The Trust's executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by Royal College of Anaesthetists in 2020. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023. The Trust Action Plan dated April 2024 noted an exception report had been accepted at the February 2024 Maternity Transformation Assurance Committee, requesting extension of the delivery deadline to June 2024 and assurance deadline to August 2024.	Final Ockendon Report (March 2022)Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024 First Ockenden Report Action Plan (Progress as at 12.09.23)		Noted as not yet delivered but on track. 021.24a-BoD-PUBLIC-February-2024_Appendix-One_-Ockenden-Report-Action-Plan-at-9-January-2024_FINAL.pdf (sath.nhs.uk)
	LafL 54 (2nd)	The Trust's anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon		

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		undertaken to ensure evidence-based care is being embedded in day-to-day practice. (March 2022)		Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 55 (2nd)	The Trust's department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting. (March 2022)	Noted in Trust Action Plan as 'not yet delivered' but progress 'on track' as at 12 September 2023. The April 2024 Action Plan noted that an exception report had been accepted at the February 2024 Maternity Transformation Assurance Committee, requesting extension of the delivery deadline to June 2024 and assurance deadline to August 2024.	Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		
30 March 2022: Neonatal						
Improving patient safety	**LafL 56 (2nd)**	The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action		

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				Plan (Progress as at 12.09.23)		
Improving patient safety	**LafL 57 (2nd)**	As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners, the Trust must have a strategy for continuing recruitment, retention and training of Advanced Neonatal Nurse Practitioners. (March 2022)	Noted in Trust Action Plan as 'not yet delivered' but progress 'on track' as at 12 September 2023. The April 2024 Action Plan recorded the item as "*delivered, not yet evidence*" and "*at risk*". The Trust said this was because delivery was linked to approval of further funding.	Final Ockenden Report (March 2022) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024 First Ockenden Report Action Plan (Progress as at 12.09.23)		Noted in Trust Action Plan as 'not yet delivered' and at risk. 021.24a-BoD-PUBLIC-February-2024_Appendix-One_-Ockenden-Report-Action-Plan-at-9-January-2024_FINAL.pdf (sath.nhs.uk)
Improving patient safety	**LafL 58 (2nd)**	The Trust must ensure that sufficient resources are available to provide safe neonatal medical or Advanced Neonatal Nurse Practitioner cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockenden Report (March 2022) First Ockenden Report Action		

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				Plan (Progress as at 12.09.23)		
Improving patient safety	**LafL 59 (2nd)**	The number of neonatal nurses at the Trust who are "qualified-in-specialty" must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review. (March 2022)	Noted in Trust Action Plan as 'delivered' but 'not yet evidenced', though progress 'on track as at 12 September 2023'. The April 2024 Action Plan recorded the item as "*delivered, not yet evidence*" and "*at risk*". The Trust said this was because delivery was linked to approval of further funding.	Final Ockendon Report (March 2022) Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024 First Ockenden Report Action Plan (Progress as at 12.09.23)		Noted in Trust Action Plan as 'not yet delivered' and at risk. 021.24a-BoD-PUBLIC-February-2024_Appendix-One_-Ockenden-Report-Action-Plan-at-9-January-2024_FINAL.pdf (sath.nhs.uk)
30 March 2022: Postnatal						
Improving patient safety	**LafL 60 (2nd)**	The Trust must ensure that a woman's GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden		

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				Report Action Plan (Progress as at 12.09.23)		
Improving patient safety	**LafL 61 (2nd)**	The Trust must ensure complete and accurate information is given to families after any poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
30 March 2022: Staff voices						
Improving the ability to raise complaints and concerns	**LafL 62 (2nd)**	The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey. (March 2022)	Noted in April 2024 Trust Action Plan as 'delivered' but 'not yet evidenced', though progress 'on track'. The commentary recorded that a deadline extension to March 2025 had been agreed at the April 2024 Maternity Transformation Assurance Committee. It was said that it was too early in the "*cultural transformation journey*" to consider the action fully embedded.	Final Ockenden Report Action Plan, Shrewsbury and Telford Hospital NHS Trust, April 2024		
30 March 2022: Supporting families after the review is published						

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	LafL 63 (2nd)	Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families. (March 2022)	Noted in Trust Action Plan as delivered, evidenced and assured as at 12 September 2023.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23)		
	LafL 64 (2nd)	There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area. (March 2022)	Trust Board Minutes of 10 August 2023 noted that this action was 'not yet delivered' because it had been 'de-scoped' since it was an action with external dependencies and requires national action. The Trust Action Plan (as at 12 September 2023) notes the action is 'dependent on NHS England and NHS Improvement, commissioners and Mental Health Trusts'.	Final Ockendon Report (March 2022) First Ockenden Report Action Plan (Progress as at 12.09.23) Board of Directors' Meeting (August 2023)		

28 MESSENGER REVIEW OF NHS LEADERSHIP

28.1 Introduction

This review of leadership and management across health and social care was launched by the government in October 2021. It was led by Sir Gordon Messenger and supported by Dame Linda Pollard.

The report was published on 8 June 2022. The report can be viewed online. Its focus was on what is needed to improve how health and social care is managed and led in England, with particular focus on how to incentivise, support, train, and develop people in leadership roles or to undertake leadership roles.

28.2 Messenger Review: Table of Recommendations

Messenger Review						
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**	**DHSC Comments**
Improving NHS culture and governance	**1**	**Targeted interventions on collaborative leadership and organisational values:** There should be a move to greater integration, different skills, and more collaborative behaviours. New training interventions and programmes should be introduced. Action 1.1: A new, national entry-level induction for all who join health and social care. Action 1.2: A new, national mid-career programme for managers across health and social care. (June 2022)	Currently outstanding; the government has confirmed its acceptance of all 7 recommendations and that 'publication of the report will be followed by a plan committing to implementing the recommendations'. The plan itself is not yet published. The Government response in June 2023 to the House of Commons Health and Social Care Committee's report on 'Integrated care systems: autonomy and accountability' mentions the planned response to the Messenger review and that '[a] senior advisory group across health and care has been brought together to advise and help to plan a 3 year roadmap of leadership and management support and development in response to this and other reviews.'	Department of Health and Social Care Government response to the House of Commons Health and Social Care Committee's seventh report of session 2022 to 2023 (June 2023)		Action 1.1 - NHS England and Skills for Care are working towards the launch of a new national induction framework in April 2024 for all people who join the health and social care workforce. This will include a range of co-created resources for new staff, their managers and systems. Action 1.2 - Work is developing on mid-career support, with a finalised version of the Management Code and Standards expected by September 2024 following engagement and

Messenger Review						
						feedback from stakeholders. A curriculum for all levels of managers will follow shortly thereafter, linking the Code to the Standards. In the meantime, current NHSE programmes will be reviewed for core competencies and NHS strategic priorities.
	2	**Positive equality, diversity and inclusion (EDI) action:** Leaders at every level should cultivate the conditions or individuals to overcome disadvantage; ensure staff recognise and remove subtle exclusionary practices; and work to remove the unspoken assumptions in favour of certain groups in terms of career advancements. Action 2.1: Embed inclusive leadership practice as the responsibility of all leaders. Action 2.2: Commit to promoting equal opportunity and fairness standards. Action 2.3: More stringently enforce existing measures to improve equal opportunities and fairness.	Currently outstanding; the government has confirmed its acceptance of all 7 recommendations and that 'publication of the report will be followed by a plan committing to implementing the recommendations'. The plan itself is not yet published. The Government response in June 2023 to the House of Commons Health and Social Care Committee's report on 'Integrated care systems: autonomy and accountability' mentions the planned response to the Messenger review and that '[a] senior advisory group across health and care has been brought together to advise and help to plan a 3 year roadmap of leadership and management	Department of Health and Social Care Government response to the House of Commons Health and Social Care Committee's seventh report of session 2022 to 2023 (June 2023)		NHS England has published an Equality, Diversity and Inclusion Improvement Plan (June 2023) which sets out a series of High Impact Actions including the aim to increase accountability of all leaders to embed inclusive leadership and promote equal opportunities.

Messenger Review						
		Action 2.4: Enhance the Care Quality Commission's role in ensuring improvement in equality and diversity outcomes. (June 2022)	support and development in response to this and other reviews.'			The six high impact actions are: • Measurable objectives on EDI for Chairs, CEOs and Board members • Overhaul recruitment processes and embed talent management processes • Eliminate pay gaps with respect to race, disability and gender • Address health inequalities within the workforce • Comprehensive induction and

Messenger Review						
						• onboarding programme for internationally recruited staff • Eliminate conditions and environment in which bullying, harassment and physical harassment occurs NHS England » NHS equality, diversity and inclusion (EDI) improvement plan Skills for Care have been engaging with the sector and reviewing their products to build EDI into their work.

Messenger Review						
						The CQC are developing their new assessment approach for NHS Trust well led assessments. This will consider equality, diversity and inclusion. The CQC are working on their Workforce Experience Framework, including tools for their inspectors and assessors to use to gather feedback from NHS staff about workforce equality.
Regulation and oversight of NHS managers	**3**	**Consistent management standards delivered through accredited training:** specifically within the NHS, but there is scope for the standards and core content developed to be used more widely in social care. Action 3.1: A single set of unified, core leadership and management standards for managers.	As above. Currently outstanding; the government has confirmed its acceptance of all 7 recommendations and that 'publication of the report will be followed by a plan committing to implementing the recommendations'. The plan itself is not yet published.	Department of Health and Social Care Government response to the House of Commons Health and Social Care		Action 3.1 & 3.2 - NHS England is leading work on the development of a management and leadership framework, which will include a management Code of Practice,

Messenger Review						
		Action 3.2: Training and development bundles to meet these standards. (June 2022)	The Government response in June 2023 to the House of Commons Health and Social Care Committee's report on 'Integrated care systems: autonomy and accountability' mentions the planned response to the Messenger review and that '[a] senior advisory group across health and care has been brought together to advise and help to plan a 3 year roadmap of leadership and management support and development in response to this and other reviews.'	Committee's seventh report of session 2022 to 2023 (June 2023)		standards and competencies at all defined levels of manager and core curriculum. This is being designed with stakeholder engagement commencing February 2024. Once the curriculum is finalised, a new delivery model is planned, involving a framework of quality assured / accredited providers.
Regulation and oversight of NHS managers	**4**	**A simplified, standard appraisal system for the NHS:** All staff in the NHS should have an annual appraisal. Improvement is needed to the process and quality of appraisals, irrespective of whether individuals wish to progress to higher roles or not. Action 4.1: A more effective, consistent and behaviour-based appraisal system, of value to both the individual and the system. (June 2022)	As above. Currently outstanding; the government has confirmed its acceptance of all 7 recommendations and that 'publication of the report will be followed by a plan committing to implementing the recommendations'. The plan itself is not yet published. The Government response in June 2023 to the House of Commons Health and Social Care Committee's report on 'Integrated care systems: autonomy and accountability' mentions the planned response to the	Department of Health and Social Care Government response to the House of Commons Health and Social Care Committee's seventh report of session 2022		NHS England is working to deliver a new standardised Board Appraisal Framework by September 2024. This will align with the Leadership Competency Framework produced as part of the Kark Review, which will launch in March 2024. A

Messenger Review						
			Messenger review and that '[a] senior advisory group across health and care has been brought together to advise and help to plan a 3 year roadmap of leadership and management support and development in response to this and other reviews.'	to 2023 (June 2023)		simplified appraisal system for all staff is proposed for development in 2024/25. NHS England » New standards for NHS board members to strengthen leadership and governance
Regulation and oversight of NHS managers	**5**	**A new career and talent management function for managers:** There is a need to create a more aggregated career management function to address issues of lack of clarity for career progression; the failure of the system to utilise and encourage the talent available' and the shortage of people wanting to be managers. Action 5.1: Creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers. (June 2022)	As above. Currently outstanding; the government has confirmed its acceptance of all 7 recommendations and that 'publication of the report will be followed by a plan committing to implementing the recommendations'. The plan itself is not yet published. The Government response in June 2023 to the House of Commons Health and Social Care Committee's report on 'Integrated care systems: autonomy and accountability' mentions the planned response to the Messenger review and that '[a] senior advisory group across health and care has been brought together to advise and help to plan a 3 year roadmap of leadership and management	Department of Health and Social Care Government response to the House of Commons Health and Social Care Committee's seventh report of session 2022 to 2023 (June 2023)		NHS England is working towards rolling out a suite of talent management tools in 2024 and to build on existing work in partnership with systems on talent pools and pipelines in each region, particularly towards CEO and Executive Director roles. New regional teams are forming in NHSE and targets and impact measures will be

Messenger Review						
			support and development in response to this and other reviews.'			designed shortly thereafter.
	6	**Effective recruitment and development of non-executive directors (NEDs):** The current non-executive talent and appointments team in NHS England should be expanded, scaled up, and specialised. Action 6.1: Establishment of an expanded, specialist non-executive talent and appointments team. (June 2022)	As above. Currently outstanding; the government has confirmed its acceptance of all 7 recommendations and that 'publication of the report will be followed by a plan committing to implementing the recommendations'. The plan itself is not yet published. The Government response in June 2023 to the House of Commons Health and Social Care Committee's report on 'Integrated care systems: autonomy and accountability' mentions the planned response to the Messenger review and that '[a] senior advisory group across health and care has been brought together to advise and help to plan a 3 year roadmap of leadership and management support and development in response to this and other reviews.'	Department of Health and Social Care Government response to the House of Commons Health and Social Care Committee's seventh report of session 2022 to 2023 (June 2023)		NHS England put in place a new induction programme for NEDs and Chairs in 2023. This includes events for new starters three times a year and modules of supporting information available from Spring 2024. A refresh of the NED and Chair database is also currently underway which aims to increase the breadth and diversity of talent pipelines towards NHS non-executive roles. NHSE will also relaunch the Aspirant Chair programme during 2024/25.

Messenger Review						
	7	**Encouraging top talent into challenged parts of the system:** There are insufficient incentives to move into leadership roles, and there should be a sufficient package of support to encourage leaders to take on roles that are challenging or difficult. Action 7.1: Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles. (June 2022)	As above. Currently outstanding; the government has confirmed its acceptance of all 7 recommendations and that 'publication of the report will be followed by a plan committing to implementing the recommendations'. The plan itself is not yet published. The Government response in June 2023 to the House of Commons Health and Social Care Committee's report on 'Integrated care systems: autonomy and accountability' mentions the planned response to the Messenger review and that '[a] senior advisory group across health and care has been brought together to advise and help to plan a 3 year roadmap of leadership and management support and development in response to this and other reviews.'	Department of Health and Social Care Government response to the House of Commons Health and Social Care Committee's seventh report of session 2022 to 2023 (June 2023)		NHS England will develop a digital talent platform and digital career portal. This will enable greater visibility of individuals and their skills to enable effective succession planning and will include good practice support for senior leaders moving to challenged roles/organisations. A new VSM pay framework including incentives for roles at challenged and very challenged systems and organisations is in the final stages of clearance. NHS England is working with DHSC to plan for the publication and launch of the framework once the necessary

Messenger Review						
						clearances have been granted.

29 THE INDEPENDENT MEDICINES AND MEDICAL DEVICES SAFETY REVIEW

29.1 Introduction

An Independent Review to examine how the healthcare system in England responded to reports about harmful side effects from medicines and medical devices and to consider how to respond to them more quickly and effectively in the future. The Independent Review was chaired by Baroness Julia Cumberlege CBE DL. The report of the Independent Review was published on 8 July 2020.

The Independent Review was asked to investigate what had happened in respect of three medical interventions: (i) hormone pregnancy tests (Primodos); (ii) sodium valproate; and (iii) pelvic mesh implants.

The Independent Review found that there was a lack of vigilant, long-term monitoring of outcomes in respect of medicines and medical devices. The system failed to acknowledge when things went wrong, with an institutional and professional resistance to changing practice even in the face of mounting safety concerns. The culture was a dismissive and arrogant one. The system failed to work in a joined-up fashion and lacked the leadership to deliver coherent and fully integrated patient safety policy directives and standards. There was a failure to listen to patient concerns and, when action was taken, it was too slow.

The Inquiry made 9 recommendations. The Government responded to the report of the Inquiry, and the recommendations it made, in a response published on 26 July 2021. An update report was published on 12 December 2022.

29.2 The Independent Medicines and Medical Devices Safety Review: Table of Recommendations

The Independent Medicines and Medical Devices Safety Review					
Type of Recommendation	No.	Details of Recommendation	Implementation	Source	Extent of Implementation
Improving patient safety	1	The Government should immediately issue a fulsome apology on behalf of the healthcare system to the families affected by Primodos, sodium valproate and pelvic mesh.	The Government accepted this recommendation. The Government issued an apology on 9 July 2020 on behalf of the healthcare system to the women affected, as well as their children and their families, for the time the healthcare system took to listen and respond.	The Government Response to the Report of the Independent Medicines and Medical Devices Safety Review, 26 July 2021 (https://assets.publishing.service.gov.uk/media/60fea6688fa8f50432ab9217/IMMDS_Review_-_Government_response_-_220721.pdf).	
Improving patient safety	2	The appointment of a Patient Safety Commissioner who would be an independent public leader with a statutory responsibility. The Commissioner would champion the value of listening to patients and promoting users' perspectives in seeking improvements to patient	The Government accepted this recommendation. The Commissioner for Patient Safety was created by section 1 of the Medicines and Medical Devices Act 2021. Dr Henrietta Hughes was appointed as the first Patient Safety Commissioner on 12 July 2022.	The Government Response to the Report of the Independent Medicines and Medical Devices Safety Review, 26	

The Independent Medicines and Medical Devices Safety Review					
		safety around the use of medicines and medical devices.		July 2021 (https://assets.publishing.service.gov.uk/media/60fea6688fa8f50432ab9217/IMMDS_Review_-_Government_response_-_220721.pdf). Independent Medicines and Medical Devices Safety Review: update report on government implementation, 22 December 2022 (https://www.gov.uk/government/publications/independent-medicines-and-medical-devices-safety-review-update-report-on-government-implementation/independent-medicines-and-medical-devices-safety-review-update-report-on-	

The Independent Medicines and Medical Devices Safety Review					
				government-implementation).	
Improving the ability to raise complaints and concerns	3	A new independent Redress Agency for those harmed by medicines and medical devices should be created based on models operating effectively in other countries. The Redress Agency will administer decisions using a non-adversarial process with determinations based on avoidable harm looking at systemic failings, rather than blaming individuals.	The Government rejected this recommendation. In its July 2021 response, the Government said it had no plans to establish an independent redress agency as it did not believe the same would make products safer. The Government considered that the existing ability of the government to provide redress for specific issues where that was considered necessary was sufficient.	The Government Response to the Report of the Independent Medicines and Medical Devices Safety Review, 26 July 2021 (https://assets.publishing.service.gov.uk/media/60fea6688fa8f50432ab9217/IMMDS_Review_-_Government_response_-_220721.pdf).	
Improving the ability to raise complaints and concerns	4	Separate schemes should be set up for each intervention – hormone pregnancy tests, valproate and pelvic mesh – to meet the cost of providing additional care and support to those who have experienced avoidable harm and are eligible to claim.	The Government rejected this recommendation. In its July 2021 response, the Government said that its primary focus was on improving future medicines and the safety of medical devices, with funds to be directed towards those initiatives instead of redress schemes. The Government instead referred to the right of patients to take health care providers or manufacturers to court through legal action.	The Government Response to the Report of the Independent Medicines and Medical Devices Safety Review, 26 July 2021 (https://assets.publishing.service.gov.uk/media/60fea6688	The Inquiry may want to reference the Patient Safety Commissioner's report on redress for valproate and mesh – this was

The Independent Medicines and Medical Devices Safety Review					
			On 7 February 2024, the Hughes Report – Options for redress for those harmed by valproate and pelvic mesh – was published, which recommended the Government create a two-stage financial redress scheme comprising an Interim Scheme and a Main Scheme. It was recommended the Interim Scheme should award patients a fixed sum by way of financial redress and the Main Scheme offer more bespoke financial support to patients based on their individual circumstances.	fa8f50432ab9217/IMMDS_Review_-_Government_response_-_220721.pdf). The Hughes Report: Options for redress for those harmed by valproate and pelvic mesh (patientsafetycommissioner.org.uk)	commissioned by Ministers and reported earlier this year (see The Hughes Report - Patient Safety Commissioner) (This work is also referenced in the Government's response to the Health and Care Select Committee report, which is included at Recs 6 and 7).
Improving patient safety	5	Networks of specialist centres should be set up to provide comprehensive treatment, care and advice for those affected by implanted mesh; and separately for those adversely affected by medications taken during pregnancy.	The Government accepted this recommendation in part. In its July 2021 response, the Government said that NHS England and NHS Improvement had led work to establish specialist mesh services, with 8 specialist centres in operation at that time. However, the Government considered that a network of new specialist centres for those adversely	The Government Response to the Report of the Independent Medicines and Medical Devices Safety Review, 26	

The Independent Medicines and Medical Devices Safety Review					
			affected by medicines taken during pregnancy was not the most effective way forward. Instead, it would work to improve the care pathways for children and families adversely affected by medicines in pregnancy. In its December 2022 update, the Government said 9 specialist centres were now in operation in England, amounting to a complete network of such centres. Work was ongoing for medicines in pregnancy.	July 2021 (https://assets.publishing.service.gov.uk/media/60fea6688fa8f50432ab9217/IMMDS_Review_-_Government_response_-_220721.pdf). Independent Medicines and Medical Devices Safety Review: update report on government implementation, 22 December 2022 (https://www.gov.uk/government/publications/independent-medicines-and-medical-devices-safety-review-update-report-on-government-implementation/independent-medicines-and-medical-devices-safety-review-update-report-on-	

The Independent Medicines and Medical Devices Safety Review					
				government-implementation).	
Improving patient safety	6	The Medicines and Healthcare products Regulatory Agency needs substantial revision particularly in relation to adverse event reporting and medical device regulation. It needs to ensure that it engages more with patients and their outcomes. It needs to raise awareness of its public protection roles and to ensure that patients have an integral role in its work.	The Government accepted this recommendation. In its July 2021 response, the Government said that the Medicines and Healthcare products Regulatory Agency had initiated a programme of work to improve how it listened and responded to patients and the public, to develop a more responsive system for reporting adverse incidents, and to strengthen the evidence to support timely and robust decisions that protect patient safety. In its December 2022 update, the Government said that work was ongoing on this recommendation, with the Medicines and Healthcare Products Regulatory Agency establishing a new organisational structure to implement this recommendation. In January 2023, the Health and Social Care Select Committee noted that a revision of adverse reporting regulation had not yet been implemented.	The Government Response to the Report of the Independent Medicines and Medical Devices Safety Review, 26 July 2021 (https://assets.publishing.service.gov.uk/media/60fea6688fa8f50432ab9217/IMMDS_Review_-_Government_response_-_220721.pdf). Independent Medicines and Medical Devices Safety Review: update report on government implementation, 22 December 2022 (https://www.gov.uk/government/publications/independe	

The Independent Medicines and Medical Devices Safety Review					
				nt-medicines-and-medical-devices-safety-review-update-report-on-government-implementation/independent-medicines-and-medical-devices-safety-review-update-report-on-government-implementation). Follow-up on the IMMDS report and the Government's response - Health and Social Care Committee (parliament.uk)	
Improving patient safety	7	A central patient-identifiable database should be created by collecting key details of the implantation of all devices at the time of the operation. This can then be linked to specifically created registers to research and audit the outcomes both in terms of the device safety and patient reported outcomes measures.	The Government accepted this recommendation. Section 19 of the Medicines and Medical Devices Act 2021 created a power for the Secretary of State to regulate for the establishment of a UK-wide medical device information system. In its July 2021 response, the Government referred to funding set aside for a package of work to develop and test the system.	The Government Response to the Report of the Independent Medicines and Medical Devices Safety Review, 26 July 2021 (https://assets.publi	

The Independent Medicines and Medical Devices Safety Review					
			In its December 2022 update, the Government said that a scoping exercise had been undertaken to determine how best to deliver the recommendation and that it had concluded that, for England, expanding the coverage breadth of existing registries would best deliver harmonised data collections that contained patient, device and outcome-level data. In January 2023, the Health and Social Care Select Committee noted that a central patient-identifiable database had not yet been created. In a letter to the Select Committee, the Independent Medicines and Medical Devices Safety Review team said that this represented "*a serious risk to patient safety*". Rollout of the Medical Devices Outcome Registry began in May 2023.	shing.service.gov.uk/media/60fea6688fa8f50432ab9217/IMMDS_Review_-_Government_response_-_220721.pdf). Independent Medicines and Medical Devices Safety Review: update report on government implementation, 22 December 2022 (https://www.gov.uk/government/publications/independent-medicines-and-medical-devices-safety-review-update-report-on-government-implementation/independent-medicines-and-medical-devices-safety-review-update-report-on-	

The Independent Medicines and Medical Devices Safety Review					
				government-implementation). Follow-up on the IMMDS report and the Government's response - Health and Social Care Committee (parliament.uk)	
Improving NHS culture and governance	8	Transparency of payments made to clinicians needs to improve. The register of the General Medical Council should be expanded to include a list of financial and non-pecuniary interests for all doctors, as well as doctors' particular clinical interests and their recognised and accredited specialisms. In addition, there should be mandatory reporting for the pharmaceutical and medical device industries of payments made to teaching hospitals, research institutions and individual clinicians.	The Government accepted this recommendation in principle. In its July 2021 response, the Government said that it agreed that lists of doctors' interests should be publicly available, but that the General Medical Council register was not the best place to hold this information. Instead, the Government considered it would be best to ensure that it was a regulatory requirement that all registered healthcare professionals declared their relevant interests, to be published locally at employer level. In its December 2022 update, the Government said that it was currently piloting systems for doctors to declare their interests in NHS and independent settings, with full implementation to begin in 2023. The Government also referred to section 92 Health and Care Act 2022 as enabling the Secretary of State to make regulations requiring companies to publish or report information about their payments to the healthcare sector.	The Government Response to the Report of the Independent Medicines and Medical Devices Safety Review, 26 July 2021 (https://assets.publishing.service.gov.uk/media/60fea6688fa8f50432ab9217/IMMDS_Review_-_Government_response_-_220721.pdf). Independent Medicines and Medical Devices Safety Review:	

The Independent Medicines and Medical Devices Safety Review					
				update report on government implementation, 22 December 2022 (https://www.gov.uk/government/publications/independent-medicines-and-medical-devices-safety-review-update-report-on-government-implementation/independent-medicines-and-medical-devices-safety-review-update-report-on-government-implementation). Follow-up on the IMMDS report and the Government's response - Health and Social Care Committee (parliament.uk)	
	9	The Government should immediately set up a task force to implement this Review's	The Government accepted this recommendation in part.	The Government Response to the	

The Independent Medicines and Medical Devices Safety Review					
		recommendations. Its first task should be to set out a timeline for their implementation.	In its July 2021 response, the Government said that it had no current plans to establish an independent task force to implement the government response, but that it had established a patient reference group to work with the government in developing its response. The report of the patient reference group was published in July 2021.	Report of the Independent Medicines and Medical Devices Safety Review, 26 July 2021 (https://assets.publishing.service.gov.uk/media/60fea6688fa8f50432ab9217/IMMDS_Review_-_Government_response_-_220721.pdf). The Indepdendent Report of the Patient Reference Group, July 2021 (https://assets.publishing.service.gov.uk/media/60f73156d3bf7f568cde9213/independent-report-of-the-patient-reference-group-response-to-the-IMMDS-review-report.pdf).	

30 THE INDEPENDENT INVESTIGATION INTO MATERNITY AND NEONATAL SERVICES IN EAST KENT

30.1 Introduction

An independent, non-statutory investigation was commissioned by NHS England and NHS Improvement in 2020 to examine maternity and neonatal services provided at the Queen Elizabeth The Queen Mother Hospital and the William Harvey Hospital were operated by the East Kent Hospitals University NHS Foundation Trust ("the Trust"). The East Kent Investigation was chaired by Dr Bill Kirkup CBE and the report was delivered in October 2022. The Government published its response in July 2023. The report can be viewed online.

The East Kent Investigation explicitly sought a different approach to prior investigations/inquests and did not seek to identify multiple detailed recommendations, with Dr Bill Kirkup CBE explaining:

"*I do not think that making policy on the basis of extreme examples is necessarily the best approach; nor are those who carry out investigations necessarily the best to do it. More significantly, this approach has been tried by almost every investigation in the five decades since the Inquiry into Ely Hospital, Cardiff, in 1967-9, and it does not work. At least, it does not work in preventing the recurrence of remarkably similar sets of problems in other places*."

30.2 Independent Investigation into Maternity And Neonatal Services In East Kent: Table of Recommendations

Independent Investigation into Maternity And Neonatal Services In East Kent						
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**	**DHSC Comments**
Improving patient safety	**1**	The prompt establishment of a task force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use. (October 2022)	NHS England established the Maternity and Neonatal Outcome Group to act as a task force. The target is for their work to lead to a draft clinical outcome measurement tool which can be used as an early prompt, early surveillance or early screening system. The Government referred to the establishment by NHS England of a Reading the Signals Data Co-ordination Group, to bring together a series of data projects aiming to make sure the right data is used in the right way to identify and support trust which may be vulnerable to bad outcomes. Also reference to the perinatal quality surveillance model, with the NHS Standard Contract obliging providers to comply with the requirements set out in this model. (July 2023)	Reading the signals, Maternity and neonatal services in East Kent Report (October 2022) Government response to 'Reading the signals' (August 2023)		
Improving NHS culture and governance	**2i**	Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning. (October 2022)	The Department of Health and Social Care would lead the response in relation to compassionate care. In this role, it would commission royal colleges, NHS England, NHS Resolution regulators and research groups to map how compassionate care is currently being taught; share good practice and example of how barriers have been overcome; and identify	Reading the signals, Maternity and neonatal services in East		

Independent Investigation into Maternity And Neonatal Services In East Kent						
			where gaps depend on national level change or coordination and work with relevant bodies. (July 2023) The Government highlighted that compassionate care was an explicit theme in NHS England's 3-year delivery plan. Reference to NHS England undertaking a national quality review of pre-registration midwifery education, to inform the development of the Midwifery Safe Learning Environment Charter. Reference to the Nursing and Midwifery Council's Standards framework, published in April 2023, as well as a series of mini campaigns to support the application of future midwife standards. As to the General Medical Council, the Government considered that compassionate care was well embedded in the medical education curricula, for example through the General Medical Council's 'Promoting excellence standards' and 'Outcomes for graduates'. Also to the introduction by the General Medical Council of its Medical Licensing Assessment, to reinforce expected standards around essential skills, including communication skills and patient-centred care. The General Medical Council also said to be updated its core guidance for doctors 'Good medical practice', to include a new, stronger teamworking duty.	Kent Report (October 2022) Government response to 'Reading the signals' (August 2023)		

Independent Investigation into Maternity And Neonatal Services In East Kent						
			By spring 2024, NHS England is to offer its perinatal Culture and Leadership programme to all senior maternity and neonatal leadership teams in England, including the neonatal obstetric, midwifery and operational leads. Reference to NHS England Long Term Workforce Plan, published in June 2023, setting out plan to improve culture, leadership, wellbeing and staff retention over the next 15 years. Pilot of Maternity and Neonatal Independent Senior Advocates, who are to provide support to women and their families navigating the healthcare system and be available to families attending follow-up meetings with clinicians. Reference to new Care Quality Commission assessments framework to continue to consider compassionate care through quality statements that describe what good care looks like. Reference to NHS Resolution Clinical Negligence Scheme for Trusts — maternity incentive scheme — continuing to encourage the use of Maternity and Neonatal Voices Partnerships. By 2025, NHS England is to create a patient-reported experience measure to support this. (July 2023)			
Improving NHS culture	**2ii**	Relevant bodies, including royal colleges, professional regulators and employers, be commissioned to report on how the oversight	The Department of Health and Social Care is to coordinate activity in respect of standards, including mapping of current responsibilities around oversight	Reading the signals, Maternity and		

Independent Investigation into Maternity And Neonatal Services In East Kent						
and governance		and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance. (October 2022)	and direction; sharing of good practice and learning on proposed solutions to address gaps in roles and responsibilities in oversight and direction; and identification of gaps in oversight. Reference to existing professional standards set by the General Medical Council and the Nursing and Midwifery Council. However, it was noted that while professional standards remain the same irrespective of the stage of a clinician's careers, their employment arrangements define responsibility for clinical and educational supervision. The arrangements and those responsible for employment sanctions are different for trust-employed doctors, doctors on a training programme, doctors no longer on training programmes and locums. It is therefore essential that organisations representing employers, professional regulators and royal colleges all work together in terms of e.g. sharing information. Reference to additional guidance from the General Medical Council and the Nursing and Midwifery Council including reference to the 'Employer Link Service which provides training and guidance for use of locums and safe staffing from the Royal College of Obstetricians and Gynaecologists. (July 2023)	neonatal services in East Kent Report (October 2022) Government response to 'Reading the signals' (August 2023)		
Improving NHS culture	**3i**	Relevant bodies, including Royal College of Obstetricians and Gynaecologists, Royal	The Department of Health and Social Care is to lead the response to this recommendation in a central	Reading the signals,		

Independent Investigation into Maternity And Neonatal Services In East Kent						
and governance		College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset. (October 2022)	coordination role, with the support of NHS England, to develop an understanding of the barriers to teamwork, an issue on which they have asked the royal colleges to reflect. Through commissions from the royal colleges, the Care Quality Commission, NHS Resolution, NHS England, and the Healthcare Safety Investigation Branch, those working in healthcare and patients, the Department will coordinate reports that: (i) provide evidence through experience and examine existing research on how and where teamwork is being done well; (ii) bring together example of good practice; and (iii) consider whether, where gaps and barriers are identified, relevant bodies or government can support solutions. NHS England is scope what may be possible to improve the interprofessional experience, with an initial focus on promoting interprofessional experience pre-registration since professional behaviours start to develop at undergraduate level. It was also noted that staffing can contribute to poor teamworking, but that the target to increase midwifery training place from 2019 to 2020 would be met and that there would be an expansion in obstetrics and gynaecology training place in 2022/23 and 2023/24.	Maternity and neonatal services in East Kent Report (October 2022) Government response to 'Reading the signals' (August 2023)		
Improving NHS culture	**3ii**	Relevant bodies, including Health Education England, royal colleges and employers, be	The Department of Health and Social Care is to lead the response to this recommendation with the close	Reading the signals,		

Independent Investigation into Maternity And Neonatal Services In East Kent						
and governance		commissioned to report on the employment and training of junior doctors to improve support, teamworking and development. (October 2022)	support of NHS England, to improve the support and development of junior doctors. Through commissions from the royal colleges, the National Guardian's Office and those working in healthcare, the Department will coordinate reports that: (i) map how the support for junior doctors, and those who have yet to complete training including locums, is translated into practice, what access they have to development and how teamwork is embedded within this; (ii) identify and share good practice and learning around proposed solutions to address gaps in roles and responsibilities for supervision for specific groups; and (iii) consider whether the government and its arm's length bodies need to provide support to the system to address gaps and barriers. The response also noted the need for structured support to be kept under review and that, whilst guidance exists on access to development, it is not always implemented. (July 2023)	Maternity and neonatal services in East Kent Report (October 2022) Government response to 'Reading the signals' (August 2023)		
Improving the ability to raise complaints and concerns	**4i**	The government reconsiders bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies. (October 2022)	Reference to 3-year delivery plan setting out the approach to creating a culture of candour throughout organisations in relation to maternity and neonatal care. The Government said it would set out its position in due course on the recommendation for a bill which places a duty on public bodies not to deny, deflect	Reading the signals, Maternity and neonatal services in East Kent Report (October 2022)		
Improving NHS culture	**4ii**	Trusts be required to review their approach to reputation management and to ensuring there				

Independent Investigation into Maternity And Neonatal Services In East Kent						
and governance		is proper representation of maternity care on their boards. (October 2022)	and conceal information from families and other bodies. As of 6 December 2023, the government has published its response to Bishop James Jones' 2017 report on the experiences of the families bereaved by the Hillsborough disaster in this regard. A new Improving patient safety Incidence Response Framework is to be embedded in Trusts by autumn 2023 — a contractual requirement under the NHS Standard Contract, setting out requirements for providers to work compassionately with those affected by an incident. NHS England has asked all trusts and integrated care boards to review all the recommendation, including their approach to reputation management, at their next public board meeting. NHS England commissioning a support programme for 2023-24 for board safety champions to focus on developing leadership, culture and processes needed to be able to use qualitative and quantitative data to improve maternity and neonatal safety.	Government response to 'Reading the signals' (August 2023)		
Regulation and oversight of NHS managers	**4iii**	NHS England reconsiders its approach to poorly performing trusts, with particular reference to leadership. (October 2022)				The DHSC published the terms of reference for its Duty of Candour Review in December 2023. The review will consider the design of the statutory (organisational) duty of candour and its operation (including compliance and enforcement) to assess its effectiveness and make advisory recommendations. The review will focus on solutions in response to concerns within independent reports that the duty is not always met as intended, and will focus on consideration of 3 aspects relating to the duty:

Independent Investigation into Maternity And Neonatal Services In East Kent						
						1. To what extent the policy and its design are appropriate for the health and care system in England. 2. To what extent the policy is honoured, monitored and enforced. 3. To what extent the policy has met its objectives. Duty of candour review: terms of reference - GOV.UK (www.gov.uk)

Independent Investigation into Maternity And Neonatal Services In East Kent						
Regulation and oversight of NHS managers **Improving patient safety**	**5**	That the trust: • accepts the reality of these findings • acknowledges in full the unnecessary harm that has been caused • embarks on a restorative process addressing the problems identified, in partnership with families, publicly and with external input. (October 2022)	On receiving the report on 19 October 2022, the trust apologised unreservedly and publicly accepted all of the findings. On 21 October 2022, the trust board held a public extraordinary board and formally accepted the report in full and committed to addressing the areas for action in the report and the recommendation for the trust. In February 2023, the trust set out its response to the report which was published alongside an open letter of apology to the public and shared with every member of staff. Specifically, the trust: • has set up a 'Reading the signals' oversight group which reports directly to the board of directors and provides oversight of the trust's response to *Reading the Signals* and makes sure there is appropriate engagement with patients, their families and the community to oversee, challenge and advise on how the trust embarks and embeds the restorative process required to address the problems identified in the report. • has established an independent case review process for families who have	Reading the signals, Maternity and neonatal services in East Kent Report (October 2022) Government response to 'Reading the signals' (August 2023)		

Independent Investigation into Maternity And Neonatal Services In East Kent						
Improving the ability to raise complaints and concerns			concerns about maternity or neonatal care they received from the trust. • has so far held discussions with more than 4,500 women about all aspects of their and their baby's care, giving opportunities for staff recognition, learning and action. There are clear action plans to address feedback. • has developed a new bereavement pathway. Specialist bereavement midwives have worked with families and SANDS, the saving babies lives charity, to improve and expand the emotional and practical support provided to families. This includes any subsequent pregnancies, labour and delivery and has resulted in a new model of care which includes a newly recruited team providing a 7-day service. • is adopting NHS England's Culture and Leadership Programme developed by the Kings Fund as part of the commitment to			

Independent Investigation into Maternity And Neonatal Services In East Kent						
NHS Improving NHS culture and governance			nurture compassionate leaders and effective teams that work well together. • is creating an organisational culture which feels psychologically safe enough to speak up, learn and improve in. The trust expanded its freedom to speak up (FTSU) team and have seen a 269% increase in people contacting them (155 times in 2022 to 2023). • has implemented a rapid incident review process to ensure that potential serious incidents are formally highlighted, and immediate safety improvements have been actioned. • has recruited a new experienced, substantive director and deputy director of midwifery. • as part of dying matters week in May 2023, has made a caring with compassion video which is being used in mandatory training for all trust staff.			

31 INDEPENDENT INQUIRY INTO CHILD SEXUAL ABUSE (IICSA)

31.1 Introduction

The Independent Inquiry into Child Sexual Abuse ('the Inquiry') was established in 2015 to consider the extent to which state and non-state institutions have taken seriously their duty of care to protect children from child sexual abuse in England and Wales. The Chair of the Inquiry at the time of the final publication was Professor Alexis Jay OBE.

The Inquiry examined the responses of a broad range of institutions and organisations to allegations of child sexual abuse. It has considered a huge and complex picture to spot similarities, patterns and any unique circumstances. The breadth of the Inquiry's investigations across diverse settings has identified many common themes directly relevant to child sexual abuse. These themes have occurred across many different institutions.

The final inquiry report was published on 20 October 2022. The report can be viewed online. In total the inquiry has made 20 recommendations. These final recommendations complement the 87 recommendations contained in the previously published investigation reports (including six which have been restated).

Whilst the Thirlwall inquiry does not pertain to the sexual abuse of children, a number of recommendations in the Inquiry into Child Sexual Abuse are relevant to the safeguarding and protection of children which have been reviewed below.

31.2 Independent Inquiry into Child Sexual Abuse: Table of Recommendations

Independent Inquiry into Child Sexual Abuse					
Type of recommendation	**No.**	**Details of Recommendation**	**Implementation**	**Source**	**Extent of Implementation**
October 2022 – Final Report					
Improving patient safety	**2**	***Child Protection Authorities for England and for Wales.*** The Inquiry recommends that the UK government establishes a Child Protection Authority for England and the Welsh Government establishes a Child Protection Authority for Wales. Each Authority's purpose should be to: • improve practice in child protection; • provide advice and make recommendations to government in relation to child protection policy and reform to improve child protection; and, • inspect institutions and settings as it considers necessary and proportionate. The Child Protection Authorities in England and in Wales should also monitor the implementation of the Inquiry's recommendations. *(October 2022)*	Government response to final report (25 May 2023): Accepted. *"We will ensure the relevant actions included within our reform programme, Stable Homes, Built on Love, fulfil this recommendation."* *"…plan to achieve the desired effect of the recommendation without the creation of a new body, but rather ensuring that the existing mechanisms are all working as effectively and as cohesively as possible"* *"The Child Safeguarding Practice Review Panel, established in June 2018… an ideal body in England for providing some of the additional protections described in the Inquiry's Final Report".*	Secretary of State for the Home Department, 'Government response to the final report of the Independent Inquiry into Child Sexual Abuse' (Policy paper, 25 May 2023)	
	3	***A cabinet Minister for Children.***	Government response to final report (25 May 2023): Accepted.	Secretary of State for the Home Department,	

Independent Inquiry into Child Sexual Abuse					
		The Inquiry recommends that the UK government creates a cabinet-level ministerial position for children. The Inquiry recommends that the Welsh Government ensures that there is cabinet-level ministerial responsibility for children. *(October 2022)*	*"We accept the importance of placing the best interests of the child front … This role is already fulfilled through the work of the Secretary of State for Education."* A Child Protection Ministerial Group has been established previously and the work may come under this body.	'Government response to the final report of the Independent Inquiry into Child Sexual Abuse' (Policy paper, 25 May 2023)	
Improving patient safety	**9**	***Greater use of the Disclosure and Barring Service barred list.*** The Inquiry recommends that the UK government enables any person engaging an individual to work or volunteer with children on a frequent basis to check whether or not they have been barred by the Disclosure and Barring Service from working with children. These arrangements should also apply where the role is undertaken on a supervised basis. *(October 2022)*	Government response to final report (25 May 2023): Accepted. *"We accept subject to further assessment of feasibility and impact, taking into account the findings of the Bailey Review of Disclosure and Barring Regime published in April 2023."*	Secretary of State for the Home Department, 'Government response to the final report of the Independent Inquiry into Child Sexual Abuse' (Policy paper, 25 May 2023)	
Improving patient safety	**10**	***Improvements to compliance with statutory duties to refer concerns to the Disclosure and Barring Service.*** The Inquiry recommends that the UK government takes steps to improve compliance by regulated activity providers with their statutory duty to refer concerns about the suitability of individuals to work with children to the Disclosure and Barring Service, including: • all relevant regulators and inspectorates include compliance with the statutory duty to refer to the Disclosure and Barring Service in	Government response to final report (25 May 2023): Accepted. *"We accept the need to improve compliance with statutory duties to inform the Disclosure and Barring Service about individuals who may pose a risk of harm to children. We will work with the relevant bodies to do so."*	Secretary of State for the Home Department, 'Government response to the final report of the Independent Inquiry into Child Sexual Abuse' (Policy paper, 25 May 2023)	

Independent Inquiry into Child Sexual Abuse					
		their assessment of safeguarding procedures during inspections; • the National Police Chiefs' Council works with relevant regulators and inspectorates to ensure that there are clear arrangements in place to refer breaches of the duty to refer to the police for criminal investigation; and • an information-sharing protocol is put in place between the Disclosure and Barring Service and relevant regulators and inspectorates. *(October 2022)*			

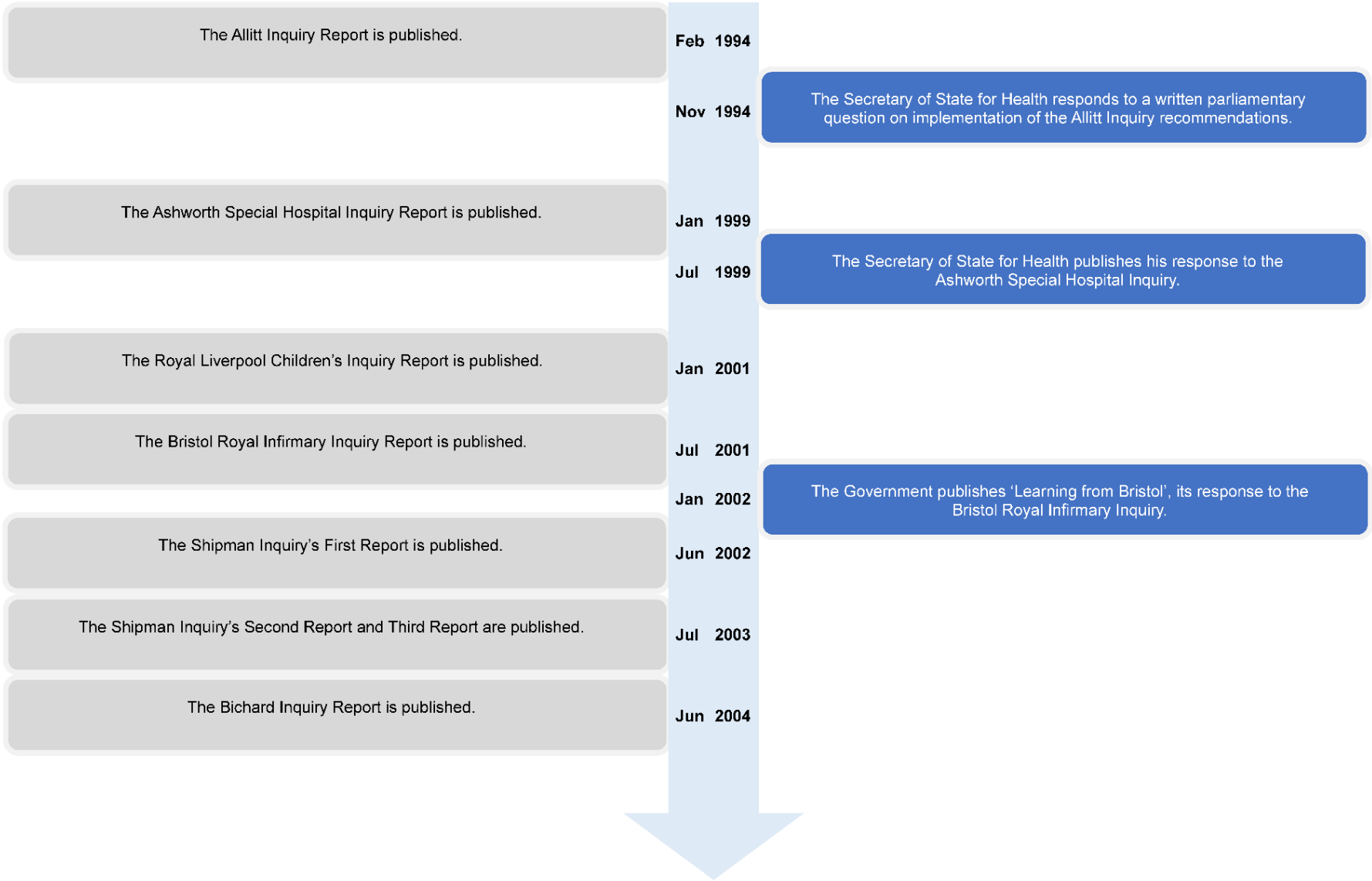
END

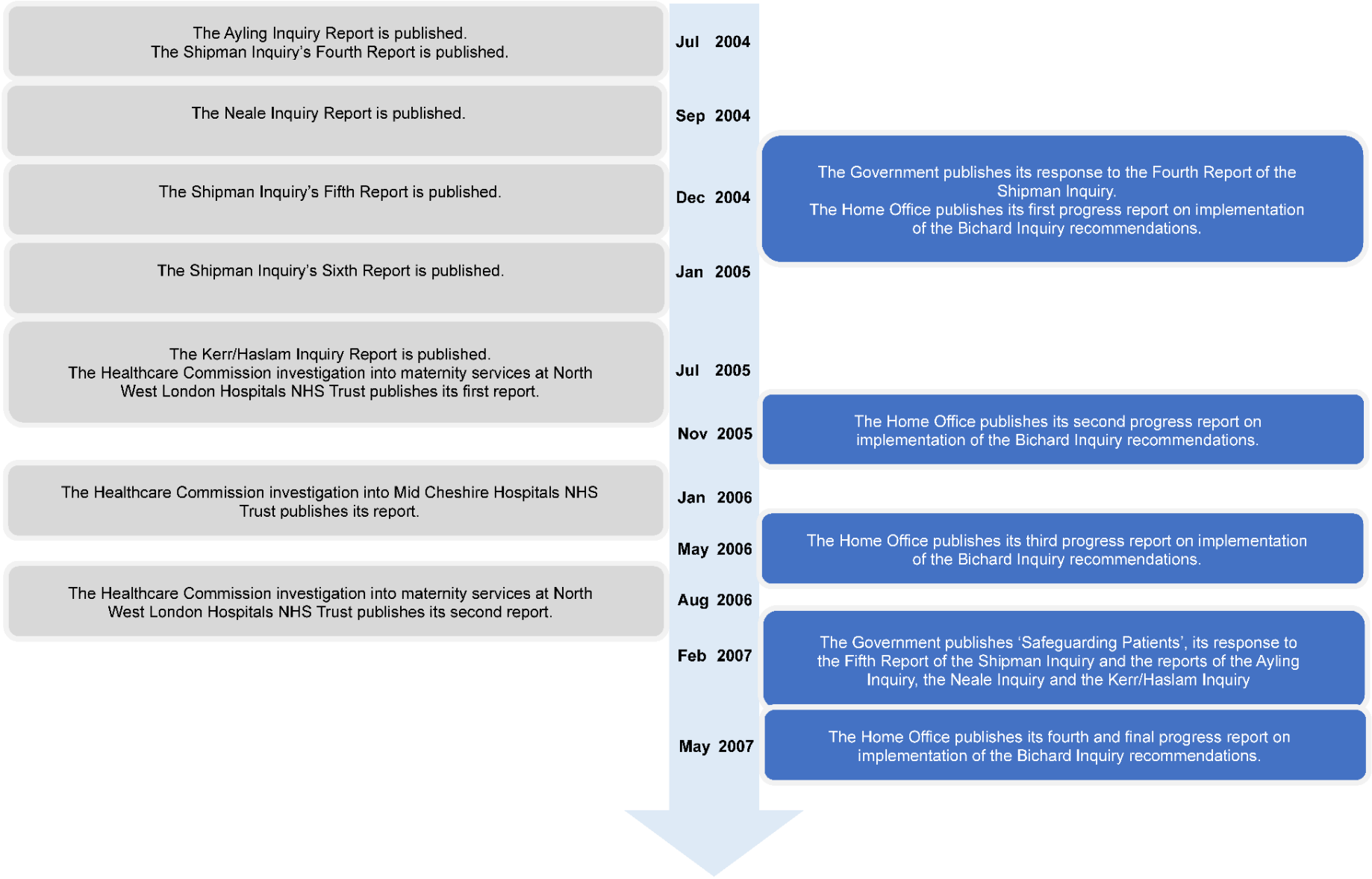
Appendix 1

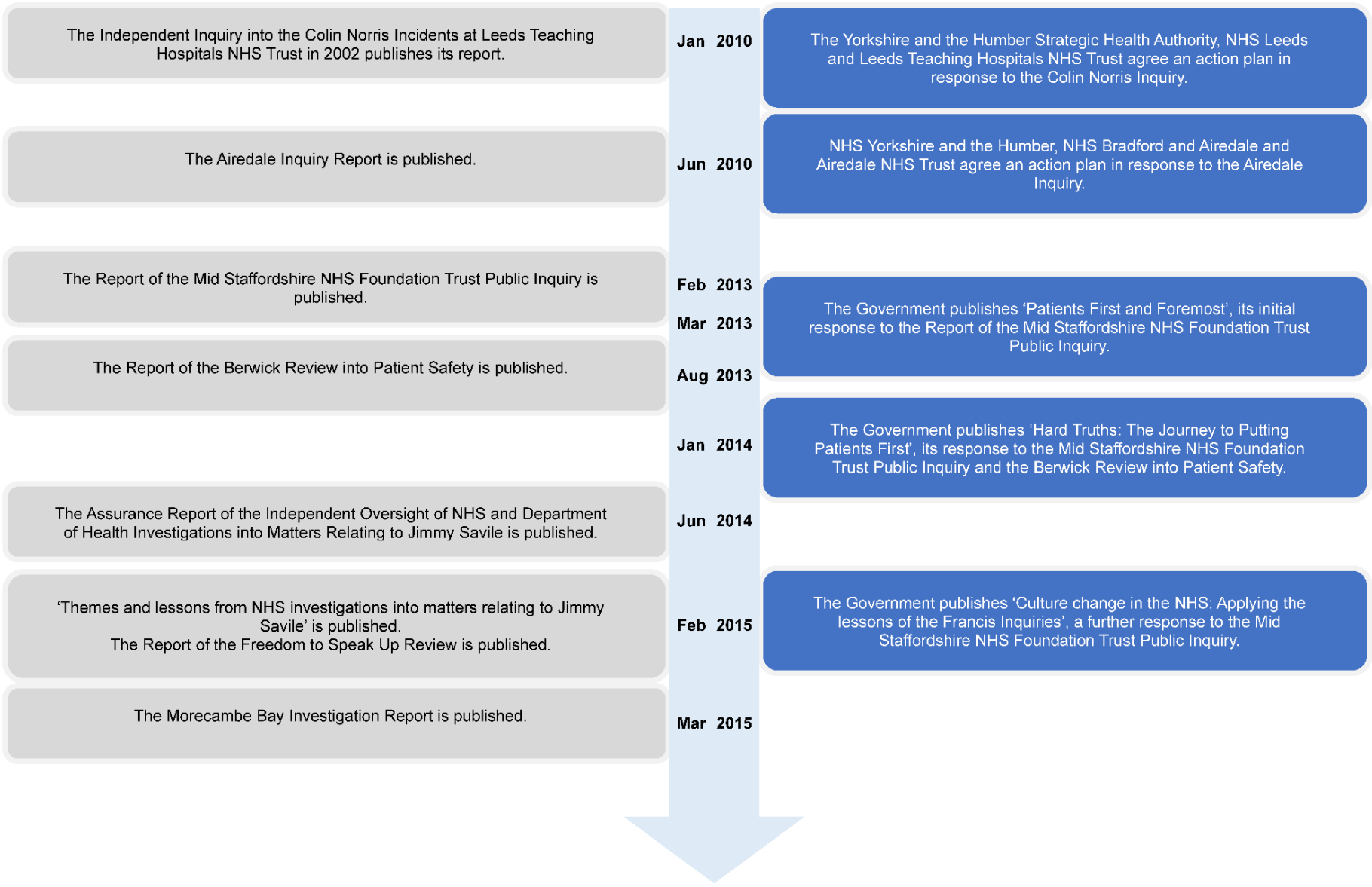
The following pages in this appendix feature a chronology which sets out on a timeline the date of each inquiry report and the key date(s) when the recommendations made in each report were implemented.

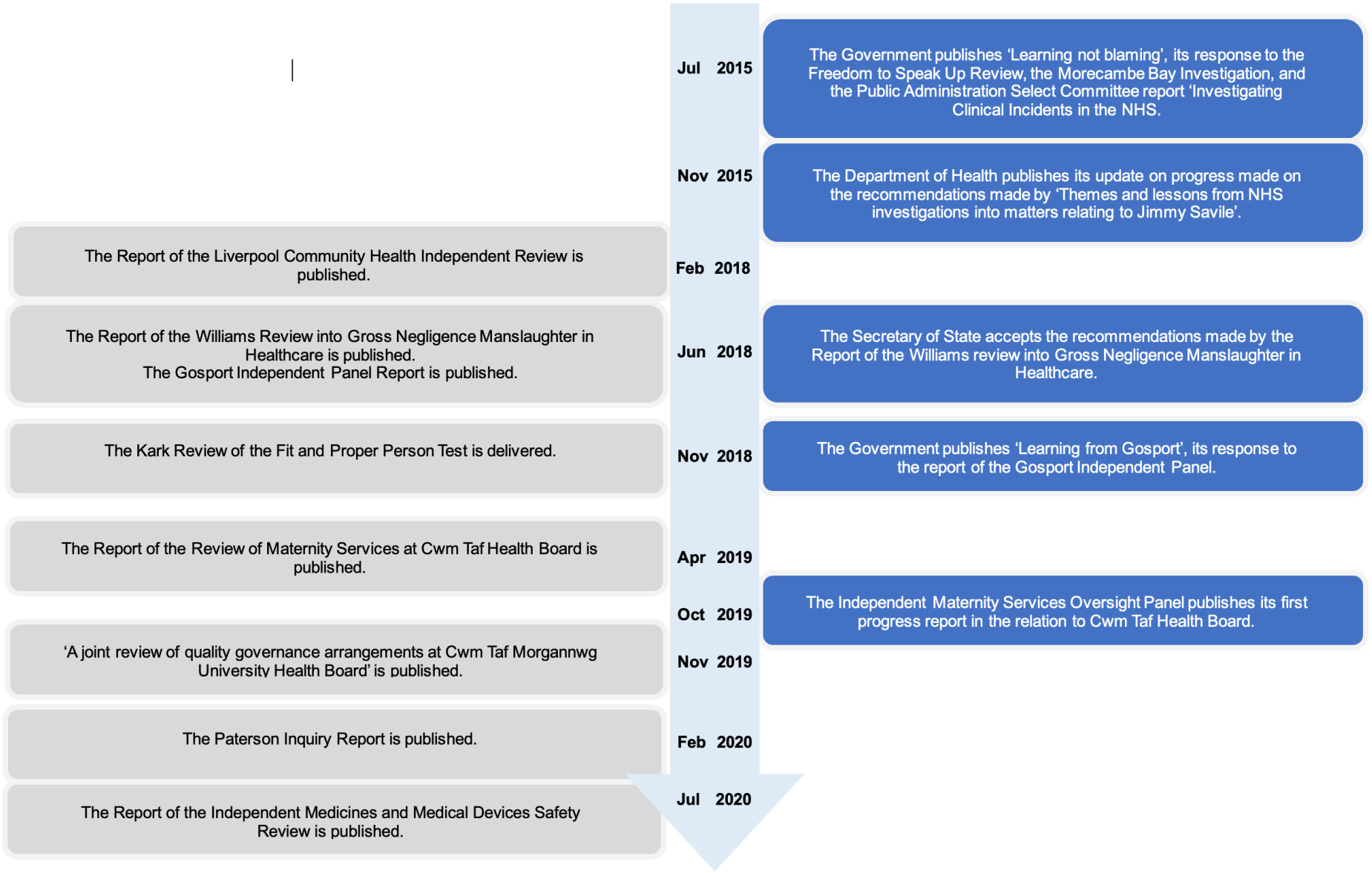
The Inquiry is aware that the Independent review into Maternity and Neonatal services in Swansea Bay was announced in December 2023. The review is likely to conclude in the Autumn of 2024. The timeline and tables above will be updated if necessary once this review has concluded.

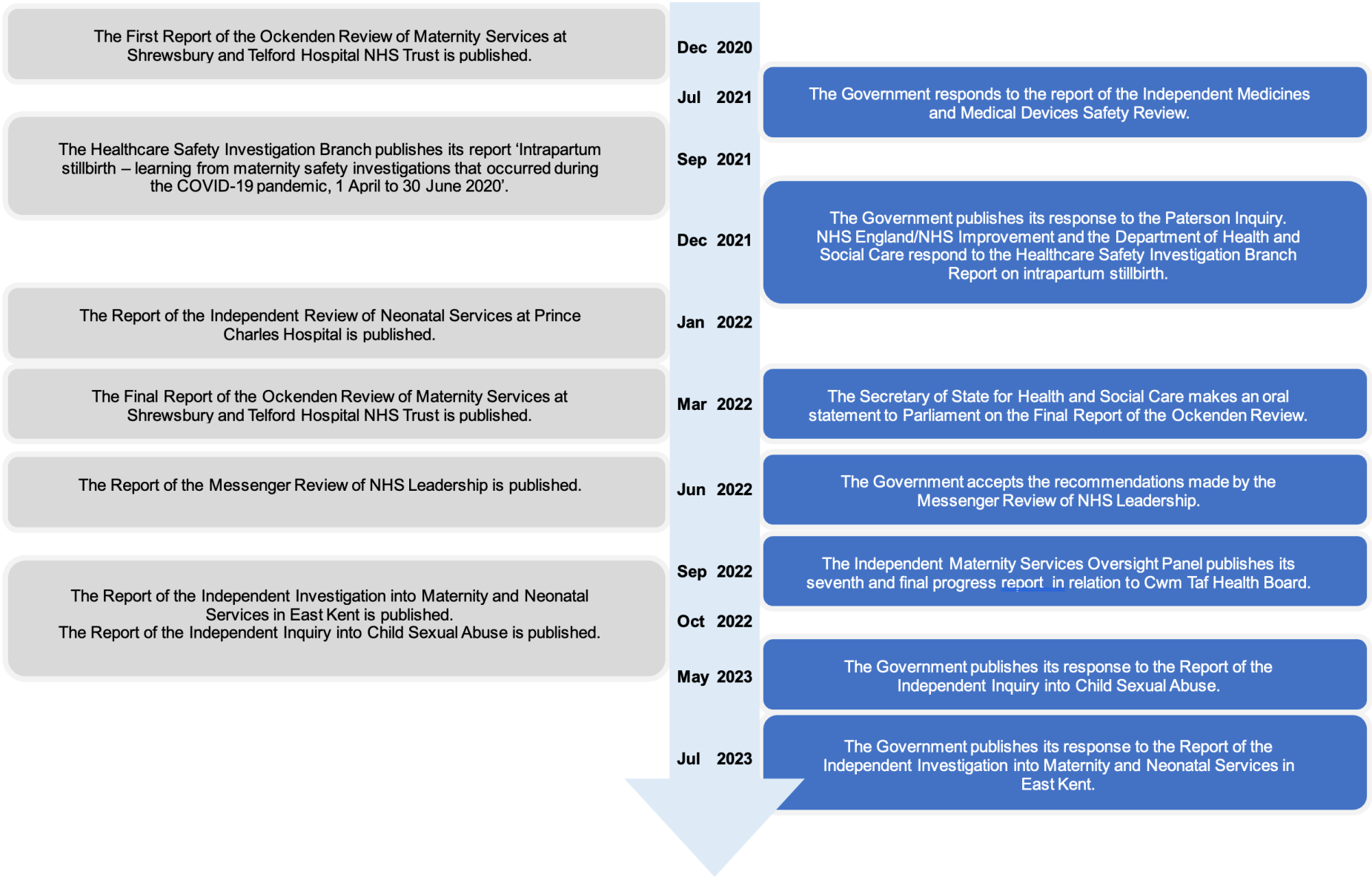
Chronology of Inquiry/Investigation Reports and Relevant Responses




The Ayling Inquiry Report is published.
The Shipman Inquiry's Fourth Report is published.
Jul 2004
The Neale Inquiry Report is published.
Sep 2004
The Shipman Inquiry's Fifth Report is published.
Dec 2004
The Government publishes its response to the Fourth Report of the Shipman Inquiry.
The Home Office publishes its first progress report on implementation of the Bichard Inquiry recommendations.
The Shipman Inquiry's Sixth Report is published.
Jan 2005
The Kerr/Haslam Inquiry Report is published.
The Healthcare Commission investigation into maternity services at North West London Hospitals NHS Trust publishes its first report.
Jul 2005
Nov 2005
The Home Office publishes its second progress report on implementation of the Bichard Inquiry recommendations.
The Healthcare Commission investigation into Mid Cheshire Hospitals NHS Trust publishes its report.
Jan 2006
May 2006
The Home Office publishes its third progress report on implementation of the Bichard Inquiry recommendations.
The Healthcare Commission investigation into maternity services at North West London Hospitals NHS Trust publishes its second report.
Aug 2006
Feb 2007
The Government publishes 'Safeguarding Patients', its response to the Fifth Report of the Shipman Inquiry and the reports of the Ayling Inquiry, the Neale Inquiry and the Kerr/Haslam Inquiry
May 2007
The Home Office publishes its fourth and final progress report on implementation of the Bichard Inquiry recommendations.


The Independent Inquiry into the Colin Norris Incidents at Leeds Teaching Hospitals NHS Trust in 2002 publishes its report.
Jan 2010
The Yorkshire and the Humber Strategic Health Authority, NHS Leeds and Leeds Teaching Hospitals NHS Trust agree an action plan in response to the Colin Norris Inquiry.
The Airedale Inquiry Report is published.
Jun 2010
NHS Yorkshire and the Humber, NHS Bradford and Airedale and Airedale NHS Trust agree an action plan in response to the Airedale Inquiry.
The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry is published.
Feb 2013
Mar 2013
The Government publishes 'Patients First and Foremost', its initial response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.
The Report of the Berwick Review into Patient Safety is published.
Aug 2013
Jan 2014
The Government publishes 'Hard Truths: The Journey to Putting Patients First', its response to the Mid Staffordshire NHS Foundation Trust Public Inquiry and the Berwick Review into Patient Safety.
The Assurance Report of the Independent Oversight of NHS and Department of Health Investigations into Matters Relating to Jimmy Savile is published.
Jun 2014
'Themes and lessons from NHS investigations into matters relating to Jimmy Savile' is published.
The Report of the Freedom to Speak Up Review is published.
Feb 2015
The Government publishes 'Culture change in the NHS: Applying the lessons of the Francis Inquiries', a further response to the Mid Staffordshire NHS Foundation Trust Public Inquiry.
The Morecambe Bay Investigation Report is published.
Mar 2015


Jul 2015
The Government publishes 'Learning not blaming', its response to the Freedom to Speak Up Review, the Morecambe Bay Investigation, and the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS.
Nov 2015
The Department of Health publishes its update on progress made on the recommendations made by 'Themes and lessons from NHS investigations into matters relating to Jimmy Savile'.
Feb 2018
The Report of the Liverpool Community Health Independent Review is published.
Jun 2018
The Report of the Williams Review into Gross Negligence Manslaughter in Healthcare is published.
The Gosport Independent Panel Report is published.
The Secretary of State accepts the recommendations made by the Report of the Williams review into Gross Negligence Manslaughter in Healthcare.
Nov 2018
The Kark Review of the Fit and Proper Person Test is delivered.
The Government publishes 'Learning from Gosport', its response to the report of the Gosport Independent Panel.
Apr 2019
The Report of the Review of Maternity Services at Cwm Taf Health Board is published.
Oct 2019
The Independent Maternity Services Oversight Panel publishes its first progress report in the relation to Cwm Taf Health Board.
Nov 2019
'A joint review of quality governance arrangements at Cwm Taf Morgannwg University Health Board' is published.
Feb 2020
The Paterson Inquiry Report is published.
Jul 2020
The Report of the Independent Medicines and Medical Devices Safety Review is published.


The First Report of the Ockenden Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust is published.
Dec 2020
Jul 2021
The Government responds to the report of the Independent Medicines and Medical Devices Safety Review.
The Healthcare Safety Investigation Branch publishes its report 'Intrapartum stillbirth – learning from maternity safety investigations that occurred during the COVID-19 pandemic, 1 April to 30 June 2020'.
Sep 2021
Dec 2021
The Government publishes its response to the Paterson Inquiry.
NHS England/NHS Improvement and the Department of Health and Social Care respond to the Healthcare Safety Investigation Branch Report on intrapartum stillbirth.
The Report of the Independent Review of Neonatal Services at Prince Charles Hospital is published.
Jan 2022
The Final Report of the Ockenden Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust is published.
Mar 2022
The Secretary of State for Health and Social Care makes an oral statement to Parliament on the Final Report of the Ockenden Review.
The Report of the Messenger Review of NHS Leadership is published.
Jun 2022
The Government accepts the recommendations made by the Messenger Review of NHS Leadership.
Sep 2022
The Independent Maternity Services Oversight Panel publishes its seventh and final progress report in relation to Cwm Taf Health Board.
The Report of the Independent Investigation into Maternity and Neonatal Services in East Kent is published.
The Report of the Independent Inquiry into Child Sexual Abuse is published.
Oct 2022
May 2023
The Government publishes its response to the Report of the Independent Inquiry into Child Sexual Abuse.
Jul 2023
The Government publishes its response to the Report of the Independent Investigation into Maternity and Neonatal Services in East Kent.