Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

FOR GENERAL RELEASE **ITEM 6**
BOARD OF DIRECTORS

Date of Meeting: **Tuesday 5 March 2013**

Title: **To consider the Trust's response to the final report and recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry**

Lead Director: **Chris Stanbury, Director of Nursing and Governance**

Report for: **Information/Decision**

This report includes/supports the following areas:

STRATEGIC GOALS:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and well being	✓
To continuously improve the quality and value of our work	✓
To recruit, develop and retain a skilled and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of our communities	✓
To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities	✓

CQC REGISTRATION: Outcomes (✓)					
Involvement and Information					
Respecting & Involving Service Users	✓	Consent to care and treatment			
Personalised care, treatment and support					
Care and welfare of people who use services	✓	Meeting nutritional needs	✓	Co-operating with other providers	✓
Safeguarding and safety					
Safeguarding people who use services from abuse	✓	Cleanliness and infection control	✓	Management of medicines	✓
Safety and suitability of premises	✓	Safety, availability and suitability of equipment	✓		
Suitability of staffing					
Requirements relating to workers	✓	Staffing	✓	Supporting workers	✓
Quality and management					
Statement of purpose	✓	Assessing and monitoring quality of service provision	✓	Complaints	✓
Notification of death of a person who uses services	✓	Notification of death or AWOL of person detained under MHA	✓	Notification of other incidents	✓
Records	✓				
Suitability of Management (only relevant to changes in CQC registration)					✓
This report does not support CQC Registration					

NHS CONSTITUTION: The report supports compliance with the pledges of the NHS Constitution (✓)					
Yes	✓	**No** (Details must be provided in Section 4 "risks")		**Not relevant**	

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1. INTRODUCTION & PURPOSE

1.1 Further to the publication of his first inquiry into the serious failings of care at Mid Staffordshire NHS Foundation Trust in 2010, Robert Francis Q.C. was appointed by the then Secretary of State in 2010 to conduct a public inquiry into those failings and the alleged failings of systems of public leadership and regulation, under the Inquiries Act of 2005. The inquiry took place from 2011 to 2012 and the final report of the findings was released by the House of Commons on Wednesday February 6th 2013.

1.2 The Trust Board of Directors had an initial discussion of the report content at its monthly seminar held on Tuesday 12th February. This paper outlines the key implications for the Trust of the findings and recommendations of the report and formally records the proposed response, for approval by the Board.

2. BACKGROUND

2.1 Mid Staffordshire General Hospitals Trust was the main provider of acute and rehabilitative care for the people of Stafford and the surrounding area. During the period of 2005 to 2008 standards of care had fallen to what has been described as 'appalling' with a significant rise in mortality above levels for comparable providers and populations. Within that time frame the Board of Directors successfully led the trust through the Monitor authorisation process to achieve Foundation Trust status, being renamed as Mid Staffordshire NHS Foundation Trust.

2.2 In the same time period, serious concerns were being raised by patients and their families -but not only had the Trust met requirements for Monitor authorisation, it had been assessed as compliant with the Health Care Commission Standards for Better Health, been rated as achieving the National Health Service Litigation Authority risk standards and no concern had been raised by local health and scrutiny or public involvement bodies. The Trust had been subject to scrutiny by the Strategic Health Authority and Department of Health as part of the foundation trust application but it was the public complaints and pressure groups that brought to light the care failings. It was those failings that were first investigated by Robert Francis in a non statutory inquiry that focused on the direct care delivery.

2.3 TEWV responded to findings and recommendations of the first report by Robert Francis with a comprehensive action plan that was monitored by the Board of Directors. These actions laid the foundations for a range of improvement work streams that remain relevant to this current Mid Staffordshire Inquiry report.

3 KEY ISSUES

3.1 The findings of the report are grouped into themes and outlined in the Executive Summary of the public inquiry report: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018

These refer to:

- Warning signs available and missed
- Longstanding problems at Trust Board level and paralleled in systems throughout the organisation including negative culture, poor governance, professional disengagement, lack of risk or performance management of staffing levels and standards of care, patients' voice not being heard and the wrong prioritisation of business.
- Restrictions and failures of patient and public involvement
- Roles and performance of the statutory bodies in scrutiny and monitoring
- Roles, responsibilities and performance of health and professional regulators
- Responsibilities and activities of other national bodies involved

3.2 A theme of the analysis of evidence was why the failings were not discovered sooner, including the identification of organisational lack of insight and lack of openness in dealings with key stakeholders. Gaps in the systems for external monitoring and regulation were exacerbated by poor information and intelligence sharing across the health and social care systems. This was found to be further compounded by constant structural reorganisation that led to loss of organisational memory and assumptions of positive assurance gathered by previous bodies. A major finding however was the focus of the assurance system being not on the quality of direct care delivery to the patient but on the organisational systems and processes and the attainment of targets.

3.3 The findings lead to the identification of 119 lessons learned and 290 recommendations for different elements of the healthcare systems. The overall aim is to support fundamental culture change and "put patients where they are entitled to be – the first and foremost consideration of the system and everyone who works in it". The recommendations are currently being explored in detail by the Department of Health with the view to publishing a response as to which ones will be endorsed and directives/actions put in place to achieve.

3.4 The TEWV Board of Directors want to ensure that the Trust:

- Develops a proportionate response to the recommendations that are relevant to TEWV;
- It follows the advice of Robert Francis in getting on and taking appropriate action without waiting to be told.

The Board and the Executive Management Team have also agreed a period of member, governor and staff briefing and consultation to gather views and ideas regarding the recommendations and the proposed actions the Trust should take to address the relevant recommendations. This was to ensure the voice of the community that the Trust serves was included in the Trust response. These interactive events are proposed to be held in each locality, led by Board members supported by external facilitation to promote participation and involvement in the discussions. The consultation will help shape the final Trust response. The initial list of relevant recommendations is attached as Appendix 1.

3.5 It was recognised that there are some key overall implications for the Trust as a healthcare provider to be drawn from the very detailed recommendations - the Trust will need to:

- Ensure a positive culture of involvement and openness, creating opportunities for feedback and review.
- Promote further the use of information and intelligence on the quality of care delivery.
- Ensure a focus on outcomes of care and outcome based performance.
- Develop further the systems of complaints, PALS, incident management and experience monitoring to highlight the voice of service users, their families and carers.
- Develop further the assurance systems and assurance information to enable monitoring and visibility of the quality of care.
- Ensure risk based systems of resource allocation and management.
- Focus on the professional roles, standards and accountability for care delivery.
- Support the effective functioning of the Board of Directors and senior management to maintain the focus on quality of patient centred care.

3.6 In reviewing the implications for the Trust there has also been consideration of ongoing work streams in relation to the findings and recommendations of the report. Many of the areas highlighted in recommendations are already being explored/developed, some examples are:

- Culture and values – the Trust has established an active 'Living the Values' programme as well as guidance on the underpinning behaviours that demonstrate the positive values promoted within the Trust. The staff development programme is supported with an awards programme that recognises where staff have demonstrated those positive behaviours as recommended by users and peers.
  The Trust is also investing in cultural development in service areas –an example is forensic services where cultural awareness survey results are supported with staff development days. That service has developed an internal staff survey to monitor issues related to the development of a positive culture.

- The Trust had endorsed the Being Open principles in 2010 and have agreed the actions for the implementation of the Duty of Candour (DH February, 2013)

following the public consultation in 2012. Both codes focus on the transparency with service users, their families and carers following incidents that actually or potentially cause harm.

- Kaizen work is being undertaken to increase the proactive involvement of families and carers in serious incident management recognising the contribution their evidence and perception can make to the analysis of the antecedents to incidents.

- The PALs and clinical assurance team have developed programmes of unannounced peer review inspections and service user led inspections of clinical service based on the Care Quality Commission patient focussed outcomes. These are aimed at increasing the transparency of service functioning and care delivery particularly giving service users the opportunity to give direct feedback.

- The Trust has invested in a system of patient experience feedback that currently covers all in-patient areas in AMH and MHSOP and some community areas but is planned to expand into a comprehensive framework for all services within the next 18 months. This ensures that patient feedback is requested at all key delivery areas. The system is also already expanding to collect carer experience – an important source of intelligence for the Trust.

- The outputs from data collected from complaints, incidents, patient experience and claims is already fed into improvement action planning but there is an improvement project ongoing at present to develop more effective processes for the dissemination and action on lessons learned.

- The programme underpinning delivery of the Payment By Results system, clinical assurance data and care pathways is identifying appropriate Clinician Rated Outcome Measures and Patient Reported Outcome Measures to support the move to outcome focussed performance management for teams. Significant progress has been made and several measures are being piloted.

- The collation, analysis and presentation of assurance and governance data has been subject to a series of development processes over the past four years and a redesign event is being planned for this year to revisit the clarity and usefulness of the data presentation in relation to monitoring of quality of care delivery. Quality Assurance data is regularly available to Board members, the Board quality sub-committee, governors and commissioners but the aim of the review is to improve the transparency and clarity of the data in relation to performance of individual clinical teams.

- The Trust agreed a framework for the education and development of health care assistants in 2012 which ensures that the Trust non registered workforce are being assessed for competency and appropriate behaviours. The

development work for values based recruitment and service user involvement in selection processes is also progressing.

Through the Trust Matrons group, together with the data from the central nursing bank, a review of ward staffing levels and clinical care demand has commenced. This will link to a national project to develop a needs based model of skill mix for Mental Health and Learning Disability nursing. This will complement the Trust work on the development of model lines and clinical pathways.

- The Board of Directors have been participating in a performance evaluation and peer appraisal scheme since Foundation Trust authorisation. This forms the basis of the Board development programme to help enable the optimum performance of the Board.

These few examples indicate the commitment of the Trust to the monitoring and improvement of the quality of care delivery and the readiness to progress the relevant recommendations.

3.7 Further to the staff briefing and consultation programme and the response by the Department of Health regarding actions to be taken by providers, the Trust will develop an action plan and form a working group to take forward the actions. In the interim work will begin on the recommendations outlined in Appendix 1 to identify and scope what work would be required to achieve the recommendations.

3.8 The Trust will be publishing their statement of intent to outline this initial response as agreed by the Board of Directors.

4. IMPLICATIONS / RISKS:

4.1 **Quality:** The findings of the Mid Staffordshire Public Inquiry highlighted extensive learning about how the quality of care can be compromised and standards of patient care fail when the focus of quality is not maintained on the experience of the patient. The risks for the Trust of not utilising the learning to address quality issues are significant. The Trust is already addressing a number of the implications as part of the ongoing improvement programme and will be prepared for the implementation of the wider recommendations once endorsed by the Department of Health.

4.2 **Financial:** There are no direct financial implications at this stage but there might be to resource the implementation of the action plan. This cannot be quantified until the action plan has been developed.

4.3 **Legal and Constitutional:** There are a range of recommendations related to the external regulation of healthcare and a proposal to amend the NHS Constitution. These will have direct implications for the Trust re the need to demonstrate compliance. The current focus by regulators and commissioners on standards of care is resulting in an increase in compliance activity and inspection for the Trust.

4.4 **Equality and Diversity:** There are no direct equality or diversity implications at this stage.

4.5 **Other Risks:** There is a risk that if all the extensive range of recommendations from the inquiry are endorsed for implementation there will be a significant demand on the Trust resources at a time when there are already a number of organisational change and improvement actions that have been agreed. Implementation plans will need to include risk assessment of change impact and ensure the Trust final response is proportionate.

5. CONCLUSIONS

5.1 The findings and recommendations from the Mid Staffordshire public inquiry demonstrate significant learning as to the causation of the failings in care at professional, organisational, systemic and regulatory level. The 290 recommendations are currently being considered by the Department of Health as to which are to be endorsed.

5.2 The Trust is establishing a series of briefings and consultation events that will inform the Trust response and clarify the actions the Trust will need to take to address the recommendations. In the interim the quality improvement activities already in place in the Trust will be mapped against the recommendations to clarify further work that is required.

6. RECOMMENDATIONS

6.1 The Board of Directors are requested to note the implications of the report and the recommendations that will require actions required of the Trust.

6.2 The Board of Directors are requested to approve the Trust's initial response for the required publication.

Chris Stanbury, Director of Nursing and Governance,
Martin Barkley, Chief Executive

APPENDIX 1

REPORT OF THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY – RECOMMENDATIONS (INITIAL IDENTIFICATION FOR PROVIDERS)

Rec. No. (Chapter No.)	Recommendation	Trust Response
	Accountability for implementation of the recommendations **These recommendations require every single person serving patients to contribute to a safer, committees and compassionate and caring service.**	
2 Chapter 20	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.	
	Putting the patient first **The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.**	
3 Chapter 21	The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations and obligations of patients.	
4 Chapter 21	The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	
5 Chapter 21	In reaching out to patients, consideration should be given to including expectations in the NHS Constitution that: • Staff put patients before themselves; • They will do everything in their power to protect patients from avoidable harm; • They will be honest and open with patients regardless of the consequences for themselves; • Where they are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so; • They will apply the NHS values in all their work.	

Rec. No. (Chapter No.)	Recommendation	Trust Response
7 Chapter 21	All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.	
8 Chapter 21	Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services.	
	Fundamental standards of behaviour **Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.**	
9 Chapter 21	The NHS Constitution should include reference to all the relevant professional and managerial codes by which NHS staff are bound, including the Code of Conduct for NHS Managers.	
10 Chapter 21	The NHS Constitution should incorporate an expectation that staff will follow guidance and comply with standards relevant to their work, such as those produced by the National Institute for Health and Clinical Excellence and, where relevant, the Care Quality Commission, subject to any more specific requirements of their employers.	
11 Chapter 20	Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and pathways as possible.	
12 Chapter 2	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.	
	Responsibility for, and effectiveness of, healthcare standards	
37 Chapter 11	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.	
39	The Care Quality Commission should introduce a mandated return from providers about patterns of complaints,	

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Chapter 11	how they were dealt with and outcomes.	
40 Chapter 11	It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.	
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions	
80 Chapter 11	A finding that a person is not a fit and proper person on the grounds of serious misconduct or incompetence should be a circumstance added to the list of disqualifications in the standard terms of a foundation trust's constitution.	
81 Chapter 11	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.	
84 Chapter 10	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.	
86 Chapter 10	A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors.	
	Effective complaints handling **Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.**	
109 Chapter 3	Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.	
110 Chapter 3	Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.	
111 Chapter 3	Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.	
112 Chapter 3	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.	

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113 Chapter 3	The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	
114 Chapter 3	Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.	
115 Chapter 3	Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply: • A complaint amounts to an allegation of a serious untoward incident; • Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion; • A complaint raises substantive issues of professional misconduct or the performance of senior managers; • A complaint involves issues about the nature and extent of the services commissioned.	
116 Chapter 3	Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	
117 Chapter 3	A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.	
118 Chapter 3	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.	
119 Chapter 3	Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.	
	Commissioning for standards	
132 Chapter 7	Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period: • Such monitoring may include requiring quality information generated by the provider. • Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases. • The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation. • Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving the healthcare	

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	regulator to focus on fundamental standards.	
133 Chapter 7	Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.	
134 Chapter 7	Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.	
	Patient, public and local scrutiny	
150 Chapter 6	Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action.	
	Openness, transparency and candour **Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.** **Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.** **Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.**	
173 Chapter 22	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	
174 Chapter 22	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	
175 Chapter 22	Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal representative).	
176 Chapter 22	Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.	
177 Chapter 22	Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	
179 Chapter 22	"Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	
180	Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the	

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Chapter 22	guidance published by the National Patient Safety Agency.	
	Nursing	
185 Chapter 23	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: • 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 achievements to enable them to acquire through training the necessary technical skills; • Training and experience in delivery of compassionate care; • Leadership which constantly reinforces values and standards of compassionate care; • Involvement in, and responsibility for, the planning and delivery of compassionate care; • Constant support and incentivisation which values nurses and the work they do through: - Recognition of achievement; − Regular, comprehensive feedback on performance and concerns; - Encouraging them to report concerns and to give priority to patient well-being.	
191 Chapter 23	Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	
194 Chapter 23	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 accurate and true reflection and be countersigned by their appraising manager as being such.	
195 Chapter 23	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	

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	would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.	
197 Chapter 23	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.	
198 Chapter 23	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".	
199 Chapter 23	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.	
202 Chapter 23	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.	
204 Chapter 23	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.	
205 Chapter 23	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.	
	Caring for the elderly **Approaches applicable to all patients but requiring special attention for the elderly**	
236 Chapter 25	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	
237 Chapter 25	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	
238 Chapter 25	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: • All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors. • Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. • The NHS should develop a greater willingness to communicate by email with relatives.	

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	• The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. • Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.	
239 Chapter 25	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	
240 Chapter 25	All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	
241 Chapter 25	The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.	
242 Chapter 25	In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.	
243 Chapter 25	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	
	Information	
244 Chapter 26	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry. • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input. • Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the	

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	individual patients and collective professional, managerial and regulatory requirements. Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.	
245 Chapter 26	Each provider organisation should have a board level member with responsibility for information.	
246 Chapter 26	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.	
247 Chapter 26	Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all systems regulators.	
248 Chapter 26	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.	
249 Chapter 26	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.	
250 Chapter 26	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.	
255 Chapter 26	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.	
262 Chapter 26	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: • Effective real-time information on the performance of each of their services against patient safety and minimum quality standards; • Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations such as the medical Royal Colleges. The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment.	
263 Chapter 26	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.	

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268 Chapter 26	Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry.	
269 Chapter 26	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.	
	Coroners and inquests **Making more of the coronial process in healthcare-related deaths**	
279 Chapter 14	So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment.	
280 Chapter 14	Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.	
281 Chapter 14	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.	