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DEBATE PACK

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Whistleblowing in the NHS and the Capsticks report into Liverpool Community Trust

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There will be a Westminster Hall debate on Whistleblowing in the NHS and the Capsticks report into Liverpool Community Trust on Wednesday 13 July 2016 from 4.30 pm to 5.30 pm. It will be led by Rosie Cooper.

This briefing provides a summary and relevant reports, and press and parliamentary coverage.

Contents

1. Background

Liverpool Community Health NHS Trust delivers community health services to people in their homes and in health centres, walk-in centres, intermediate care bed based services and GP practices across Liverpool and Sefton. The Trust also delivers specialist dental healthcare, therapies, medicine management, nutrition and dietetic services. Until the beginning of 2015, the Trust had provided health care services to HMP Liverpool.

On 22 March 2016 the specialist health and social care law firm Capsticks published the report of their independent review into significant service and governance failures at Liverpool Community Trust. The review had been commissioned by the new management team at Liverpool Community Health Trust, to understand why the problems highlighted by the Care Quality Commission and others in 2014 had taken place, and assess how much progress has been made since then.

The review was conducted in two distinct phases. The first phase looked at governance issues within the Trust from its creation in 2010 until the appointment of a new leadership team in the middle of 2014.

It found a number of failures had led to critical reports by the Care Quality Commission (CQC) and the dispute resolution organisation ACAS in 2014. These included:

• Problems in the way the Trust went about trying to deliver savings over several years which led to a shortage of clinical staff – something which the CQC identified in its critical inspection reports in early 2014.

• Failures to investigate concerns properly, including a serious assault on a clinician by a patient's family member in 2013.

• Several years in which the Trust failed to exercise proper oversight of offender health services – problems which were identified by the organisation's new leadership team, and led to the decision to enable a different NHS organisation to provide offender health services from January 2015.

• Failure to properly oversee the Trust's in-patient services, which led to the serving of two CQC warning notices in January 2014, saying the organisation needed to support staff better and have better quality checking systems to manage risk and learn from clinical incidents.

• An oppressive, top-down culture which the reports finds had its seeds several years before a report by ACAS in 2014.

The second phase of the Capsticks report looks at the Trust today and found that substantial progress has been made since the appointment

of a new leadership team at the Trust in April 2014. The report identified several areas for further improvement, these include changes to some of the Trust's committee structures, further improvements to governance arrangements, and reducing the length of board papers. The report is being made available to the CQC, the Nursing & Midwifery Council and other regulators, as well as NHS commissioners.

A panel of experts interviewed 43 current and former members of staff, and reviewed nearly 900 documents and minutes dating back to 2010. The review report and appendices cover 285 pages and the review cost £160,000.

To read the Capsticks Report please click here: Capsticks Report

The CQC carried out a further inspection of the Trust in February 2016 and still rated it as "Requires Improvement". Inspectors were satisfied that the trust had sought to address the findings of the May 2014 inspection, and that improvements had been made. However, progress to make the necessary changes was often slow and some services still required further improvement. The full CQC report is available here.

2. Press articles

Liverpool Echo, July 8 2016

Scandal-hit Liverpool NHS trust is improving but still has work to do;

Watchdog delivers verdict on Liverpool Community Health NHS Trust, where staff were bullied and harassed

Daily Mail, 2 May 2016

The bullying health chiefs who put cuts before care: Whistleblowers ignored and threatened with the sack

Nursing Times, 11 April, 2016

Former director of nursing suspended by NMC

A former nursing director has been suspended by the Nursing and Midwifery Council, after a report exposed serious failings at Liverpool Community Health NHS Trust.

Health Service Journal, 22 March 2016

Community trust's failures compared to Mid Staffordshire

A catalogue of governance and care failings at Liverpool Community Health Trust has been likened to those found at Mid Staffordshire Foundation Trust in a damning report

Nursing Times, 22 March 2016

Community trust's past failures compared to Mid Staffordshire

A catalogue of governance and care failings at Liverpool Community Health NHS Trust has been likened to those found at the former Mid Staffordshire NHS Foundation Trust in a damning report.

3. Press releases

CQC

CQC inspectors find Liverpool Community Health NHS Trust Requires Improvement

8 July 2016

England's Chief Inspector of Hospitals has told Liverpool Community Health NHS Trust that it must make further improvements to services following its latest inspection by the Care Quality Commission.

When CQC inspected in May 2014 the trust was rated as Requires Improvement overall. The trust was told it must make improvements in respect of a number of areas, including, staffing levels, waiting times and a culture in some services which was negative and on occasion intimidating.

Following the latest inspection in February 2016, the trust is still rated Requires Improvement. The full report is available on this website.

Inspectors were satisfied that the trust had sought to address the findings of the last inspection, and that improvements had been made. However, progress to make the necessary changes was often slow and some services still required further improvement.

Inspectors found there was well established multidisciplinary team working which focused on the best outcomes for patients and their families. Community services for children, young people and families and the health visiting and school nursing teams worked closely together to support children as they developed through their early years and into primary and secondary education. Health visitors supported local GP practices to help provide a more integrated service

Staffing had improved in community services since the last inspection but there were still concerns in some areas of community adult services. Team leaders in the community services for children, young people and families' had responsibility for a large number of staff. Inspectors also noted high levels of sickness in some teams.

Although waiting times in the services for adults and children, young people and families' had improved but in other areas, performance was worse than at the last inspection. Demand was so high for the paediatric speech therapy service that the trust had suspended the waiting list last year.

Inspectors were pleased to report an improvement in culture in the community inpatient service, which, at the last two inspections, was found to be very negative. All staff were clear that huge efforts had been made to change and support the delivery of intermediate care services.

Previously inspectors had found that the staff culture in some services was negative and on occasion some people found it intimidating. At this inspection inspectors found there had been significant improvements in

culture across the organisation, although the percentage of staff that had experienced harassment or bullying was worse than the national average.

The Chief Inspector of Hospitals, Professor Sir Mike Richards, said:

"It is positive to see that there has been an improvement in all areas of the inpatient services operated by the trust. This service was previously rated as requires improvement and was rated good in all areas at this inspection. It is also positive to see that there has been a significant improvement in the number of staff across most community services. I note that there has been a net increase of 57 district nurses since our last inspection – but there are still gaps in some areas.

"When we last inspected Liverpool Community Health NHS Trust we clearly identified a number of areas for improvement. It is disappointing to find that some of the issues had still not been resolved at the time of this inspection.

"I am pleased to report that patients are not waiting so long for wheelchairs, I am concerned that generally progress on waiting times has been far too slow. In addition, some waiting times, such as those in the children's speech and language therapy service, have actually got worse since the last inspection and give cause for some concern, which I know that the trust has been trying to address.

"I am still concerned that too many patients have been developing serious pressure ulcers and although we have seen some improvement, it is clear that there is much to do if Liverpool Community Health NHS Trust is to provide the level of service which its patients are entitled to expect. We will continue to monitor performance and we will return in due course to check on the trust's progress."

There was an area where inspectors identified outstanding practice:

The school nursing service had responded at short notice to a requirement to carry out a flu vaccination programme, which involved immunising 18,000 children in 200 schools over a four week period.

CQC has told the trust it must draw up a plan to address the issues found during the inspection. Inspectors will return to check that the required improvements have been made.

Liverpool Community Health NHS Trust

Latest Trust CQC Report Published

08 July 2016

The national care watchdog says Liverpool and Sefton's community-based NHS services have made a number of improvements after a series of damming inspection reports in 2014 over staff shortages and a top-down bullying culture, but there is more work still to do.

In its latest report, the Care Quality Commission found that Liverpool

Community Health NHS Trust has recruited more front-line clinicians to ensure safer staffing levels, and delivered big improvements to its intermediate care services on the Broadgreen and Aintree sites.

Inspectors also highlighted 'significant improvements' in the culture of the organisation and praised the Trust for the measures it has introduced to keep staff safe.

The findings echo the conclusions of a separate independent review, published in March 2016, which judged that the Trust had 'turned an important corner' following several years of deep-rooted problems.

The full CQC Report can be viewed here: CQC Report into Liverpool Community Health 2016

There is more work still to do though, and team of CQC inspectors, who carried out their inspection in February 2016, said the Trust's services now need to tackle a number of new areas, including:

• Ensuring the Trust properly documents the way it is responding to the NHS duty of candour.

• Ensuring robust systems in all services are in place to monitor and improve the quality of services provided.

Sue Page, interim Chief Executive at Liverpool Community Health NHS Trust, said: "We are pleased with the inspector's verdict that the changes introduced over the last two years are beginning to pay off for patients and families in Liverpool and Sefton.

"This is a big achievement for all the Trust's staff who work day in and day out to provide treatment and care.

"In particular, I am so pleased with the fantastic result secured by the nurses and other clinicians who work in our inpatient services. It was here, two years ago, where the Trust's unsafe drive for savings and top-down culture was first brought to light.

"Later this year, they will be taking the care they deliver into patients' homes.

"Today's report confirms that we are heading in the right direction but we are by no means complacent about the challenges that lie ahead and the work still to do."

Liverpool Community Health NHS Trust

Capsticks Report

22 March 2016

To read the Capsticks Report please click here: Capsticks Report

The report finds that substantial progress has been made following a series of poor inspection findings and the appointment in 2014 of a new leadership team at Liverpool Community Health NHS Trust.

Liverpool Community Health asked Capsticks, a specialist health and social care law firm, to conduct a detailed review to understand why the problems highlighted by inspectors in 2014 happened, assess how much progress has been made since then, and provide regulators with detailed information about the circumstances that led to the Trust's well-publicised problems in early 2014.

A panel of experts interviewed more than 40 (forty) current and former members of staff, and reviewed thousands of pages of documents and minutes dating back to 2010.

The review was conducted in two distinct phases. The first phase looked at governance issues within the Trust from its creation in 2010 until the the appointment of a new leadership team in the middle of 2014.

It found a number of failures had led to critical reports by the Care Quality Commission and the dispute resolution organisation ACAS in 2014. These included:

• Problems in the way the Trust went about trying to deliver savings over several years which led to a shortage of clinical staff – something which the CQC identified in its critical inspection reports in early 2014.

• Failures to investigate concerns properly, including a serious assault on a clinician by a patient's family member in 2013.

• Several years in which the Trust failed to exercise proper oversight of offender health services – problems which were identified by the organisation's new leadership team, and led to the decision to enable a different NHS organisation to provide offender health services from January 2015.

• Failure to properly oversee the Trust's in-patient services, which led to the serving of two CQC warning notices in January 2014, saying the organisation needed to support staff better and have better quality checking systems to manage risk and learn from clinical incidents.

• An oppressive, top-down culture which the reports finds had its seeds several years before the much-publicised report by the dispute resolution organisation ACAS in 2014.

The second phase of the Capsticks report looks at the Trust today. It found that while there is still work to do, the organisation has made significant progress and turned an important corner. Ninety-eight (98) per cent of the Trust's patients now say they would recommend the care they receive to their friends and family.

In summary, the reviewers identified:

• Heavy investment in safe staffing level with more than 150 nurses, health visitors and other clinicians recruited since April 2014.

• A new approach which values clinical leadership.

• Clear action that has been taken to put quality and patient safety at the heart of everything the Trust does.

• A new confidence among clinical staff, who feel they are now listened to.

• A new culture of openness and transparency.

The report is being made available to the Care Quality Commission, the Nursing & Midwifery Council and other regulators, as well as NHS commissioners.

Commenting on the report's publication, Carole Panteli, Liverpool Community Health NHS Trust's interim Director of Nursing, said: "The report is clear that the Trust lost its way a number of years ago and this can be seen in the sad catalogue of historical problems which climaxed in a series of critical inspection reports in early 2014. What happened was wrong and, on behalf of the Trust, we are sorry that these issues went unchecked and unchallenged for so long.

"Since the appointment of our new leadership team in April 2014 and embarking on our improvement journey, we've recruited more than 150 nurses,health visitors and other frontline clinicians.

"We've turned an important corner but it's important we never go back to the problems of the last few years.

"That is one of the reasons why we are working with our staff and local clinical commissioning groups to forge a different long-term future for the Trust's services: one that that liberates and empowers our clinicians to work together and with social care, GPs and other professionals to deliver joined-up NHS care and support for patients and families in neighbourhoods and localities across Liverpool and Sefton.

"Today's report confirms that we are heading in the right direction but we are by no means complacent about the challenges that lie ahead."

The independent report identified several areas for further improvement which the Trust is addressing through a detailed action plan. These include changes to some of the Trust's committee structures, further improvements to governance arrangements, and reducing the length of board papers.

If patients, their families or carers have any questions or queries about

the review, they can contact the Trust's Patient Advice and Liaison Service by telephone on 0300-7900-224, by email at csd@liverpoolch.nhs.uk or in writing to: PALS, Liverpool Community Health NHS Trust, 2nd Floor, Liverpool Innovation Park, Digital Way, Liverpool, L7 9NJ.

Review facts and figures

- Forty-three (43) individuals gave evidence for the review over 24 weeks.
- Nearly 900 documents, spanning more than 19,000 pages, were reviewed. It would take one person more than 18 days years to read all the documents.
- The review cost £160,000.
- The review report, and appendices cover 285 pages.

CQC

CQC requires improvement at Liverpool Community Health NHS Trust

29 January 2014

The Care Quality Commission has told Liverpool Community Health NHS Trust that it must make improvements to comply with national standards of quality and safety.

This follows unannounced inspections at the Trust's Headquarters site to review the Trust's district nursing and community equipment services and at Ward 35 Intermediate Care Unit. The visits took place in November and December 2013 and the reports of the inspections are published today.

The inspections were carried out in response to concerning information reported to CQC. Inspectors found the Trust was failing to meet national standards relating to care and welfare; staffing; supporting workers and assessing and monitoring the quality of service provision.

In addition, shortfalls were identified in relation to the accessibility of equipment in the district nursing and community equipment services, and the management of medicines on Ward 35 Intermediate Care Unit.

In the district nursing services inspectors found a lack of detailed handover information about patient care and a high reliance on agency staff.

Inspectors were concerned that high staff sickness rates and poor staff skill mix could impact on the Trust's ability to ensure that patients' needs were fully met.

There was a lack of clinical supervision taking place in the district nursing service and not all staff had received up to date mandatory training. Some staff told inspectors that they felt unsupported by Trust managers and that staff morale was low.

On Ward 35 staff reported that that patients had been admitted with needs more complex than was set out in the ward admission criteria. Inspectors raised concerns that staff may not be able to fully support those patients with more complex needs.

Inspectors observed staff did not always follow safe practice when administering medication and not all medicines were stored securely.

Serious concerns were raised by staff that they would be treated unfairly should they report incidents or concerns to management. At both sites inspectors saw Trust wide systems for monitoring service quality were in place, but these were not consistently followed, and were not sufficiently robust to ensure all risks were identified and managed effectively.

As a result of the inspection, CQC has issued two formal warnings to the Trust, requiring improvements in the assessment and monitoring of the quality of service provision and supporting workers. The Trust has also been told that action is required to address all other areas of non-compliance identified.

Inspectors will return to the Trust, unannounced, to check that the necessary improvements have been made.

Malcolm Bower-Brown, CQC's Regional Director for the North said:

"Undertaking unannounced inspections in response to information of concern is a vital part of CQC's role.

"The shortfalls we found against legally required national standards were extremely concerning. We have warned Liverpool Community Health NHS Trust that urgent improvements must be made.

"We are monitoring the Trust carefully, working closely with the NHS Trust Development Authority and other agencies, to ensure all the required improvements are made.

"In the meantime, anyone who is concerned about the standard of care in any registered service should not hesitate to contact us."

4. Parliamentary questions, statements and debate

4.1 PQs

Liverpool Community Health NHS Trust

Asked by: Lord Hunt of Kings Heath

To ask Her Majesty's Government whether they will establish a public inquiry into care failings in the Liverpool Community NHS Trust in the light of findings that executive directors of the trust downgraded serious risks or incidents and kept information from non-executive board members.

Answering member: Lord Prior of Brampton

We are assured by NHS Improvement that it continues to work closely with the Trust following the support provided by the NHS Trust Development Authority (NTDA). Following the Care Quality Commission's report of 2014, the NTDA took immediate steps to improve the skill set within the executive team, commissioned a board capability review and provided clinical and quality support in developing and delivering a quality improvement plan. As further issues came to light, the non-executive and the executive teams at the time of the failings were replaced.

A recent independent review made clear that the drive of the board to achieve foundation trust (FT) status was a dominant factor which contributed towards the failures of the trust. The report suggests that the board was managed in the way it was to ensure the FT application remained on track and that this led to downplaying of risks. A copy of this review, **Quality, safety and management assurance review at Liverpool Community Health NHS Trust**, is attached.

The Trust withdrew its application for FT status in January 2015. It is now actively working towards a transaction that is likely to see the trust's services being delivered by alternative providers

In addition to a new leadership team in place, a number of other measures are being progressed. There is an ongoing improvement plan, the continued support of NHS Improvement, implementation of the independent review's recommendations and a well-advanced transaction proposal that is likely to lead to the eventual disestablishment of the Trust. However we will consider the possibility of a further review with the leadership of NHS Improvement.

NHS Improvement is currently developing a new approach to authorising FTs. It will allow National Health Service trusts to demonstrate they meet the standards expected of FT status without the process becoming a serious distraction for them.

Liverpool Community Health Trust Report

04 May 2016 | Written questions | HL7920

NHS: Disclosure of Information

Asked by: Lord Hunt of Kings Heath

To ask Her Majesty's Government on what basis the contract for the existing NHS Whistleblowing Helpline has been extended, and whether they plan to further extend that contract.

Answering member: Lord Prior of Brampton

We are committed to improving openness in the National Health Service and ensuring whistleblowers receive proper support. Every NHS trust will have a 'Freedom to Speak up Guardian' who will support whistleblowers and foster an open and honest culture. The National Guardian will lead, advise, and support the local guardians in carrying out investigations on how concerns are being handled, share good practice, report on national or common themes, and identify any barriers that are preventing the NHS from having a truly safe and open culture.

The Whistleblowing Helpline was established in 2003 by the Department of Health to provide advice to NHS staff and employers on the raising of concerns and on the protection of employees who do raise concerns. The Department holds regular meetings with the provider of the Helpline, Mencap, to keep its performance under review.

In the context of changes in the broader health and care system, such as the establishment of the National Guardian and the local guardians network, the Department is considering what role the Helpline should play in ensuring support for whistleblowers. The Department extended the existing contract to allow the Helpline facility to continue operating while future options for the Helpline are considered.

26 Apr 2016 | Written questions | HL7768

NHS: Disclosure of Information

Asked by: Lord Hunt of Kings Heath

To ask Her Majesty's Government whether they will retender the existing NHS Whistleblowing Helpline; and if so, on what basis, and when.

Answering member: Lord Prior of Brampton

We are committed to improving openness in the National Health Service and ensuring whistleblowers receive proper support. Every NHS trust will have a 'Freedom to Speak up Guardian' who will support whistleblowers and foster an open and honest culture. The National Guardian will lead, advise, and support the local guardians in carrying out investigations on how concerns are being handled, share good practice, report on national or common themes, and identify any barriers that are preventing the NHS from having a truly safe and open culture.

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In the context of changes in the broader health and care system, such as the establishment of the National Guardian and the local guardians network, the Department is considering what role the Helpline should play in ensuring support for whistleblowers. The Department extended the existing contract to allow the Helpline facility to continue operating while future options for the Helpline are considered.

26 Apr 2016 | Written questions | HL7767

NHS: Disclosure of Information

Asked by: Lord Hunt of Kings Heath

To ask Her Majesty's Government what plans they have to establish a new whistleblowing reporting line for NHS professionals who wish to report abuse, neglect or safeguarding concerns.

Answering member: Lord Prior of Brampton | **Department:** Department of Health

We are committed to improving openness in the National Health Service and ensuring whistleblowers receive proper support. Every NHS trust will have a 'Freedom to Speak up Guardian' who will support whistleblowers and foster an open and honest culture. The National Guardian will lead, advise, and support the local guardians in carrying out investigations on how concerns are being handled, share good practice, report on national or common themes, and identify any barriers that are preventing the NHS from having a truly safe and open culture.

There are a number of routes for NHS staff to report a suspected or known wrongdoing, either to their employer or to a prescribed person including their professional body, or the Care Quality Commission (CQC). All whistleblowing concerns raised with the CQC are forwarded to the local inspector for consideration. This allows the CQC to identify problems or concerns in local services that it may need to act upon.

26 Apr 2016 | Written questions | HL7766

NHS: Disclosure of Information

Asked by: Lord Hunt of Kings Heath

To ask Her Majesty's Government what plans they have to procure independent advice for whistleblowers in the NHS, in the light of the recommendation in the Freedom to Speak Up report by Sir Robert Francis.

Answering member: Lord Prior of Brampton

We are committed to improving openness in the National Health Service and ensuring whistleblowers receive proper support. Every NHS trust will have a 'Freedom to Speak up Guardian' who will support whistleblowers and foster an open and honest culture. The National Guardian will lead, advise, and support the local guardians in carrying out investigations on how concerns are being handled, share good

practice, report on national or common themes, and identify any barriers that are preventing the NHS from having a truly safe and open culture.

The Whistleblowing Helpline was established in 2003 by the Department of Health to provide advice to NHS staff and employers on the raising of concerns and on the protection of employees who do raise concerns. The Department holds regular meetings with the provider of the Helpline, Mencap, to keep its performance under review.

In the context of changes in the broader health and care system, such as the establishment of the National Guardian and the local guardians network, the Department is considering what role the Helpline should play in ensuring support for whistleblowers. The Department extended the existing contract to allow the Helpline facility to continue operating while future options for the Helpline are considered.

26 Apr 2016 | Written questions | HL7765

NHS: Disclosure of Information

Asked by: Madders, Justin

To ask the Secretary of State for Health, what steps his Department is taking to address historic allegations of mistreatment of whistleblowers in the NHS.

Answering member: Ben Gummer

The Department supports the right of staff working in the National Health Service to raise concerns and expects all NHS organisations to support staff in raising concerns. We expect all NHS organisations to adopt the national whistleblowing policy for the NHS as a minimum standard, which will be published by NHS Improvement and NHS England next month, and comply with the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998.

A regulation-making power was included in the Small Business, Enterprise and Employment Act 2015 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 Department is aiming to consult shortly on draft regulations to implement this power.

NHS England, Monitor and the NHS Trust Development Authority are currently developing a 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. This scheme will be piloted in the next financial year.

23 Mar 2016 | Written questions | 31153

Topical Questions

Asked by: Rosie Cooper

I believe that the Capsticks governance review, published today, will show that serious harm was caused to patients and staff, that there was

a culture of bullying and harassment even after the Francis inquiry, and that Liverpool Community Health NHS Trust is the community equivalent of Mid Staffs. In the spirit of openness and transparency, will the Secretary of State instigate a public inquiry to establish the full extent of the harm caused to patients and staff?

Answered by: Ben Gummer

May I commend the hon. Lady for the brave stance that she has taken on this difficult issue? I will certainly take her concerns seriously. I want to read the report now that it has been delivered, and will speak to her at the earliest possible opportunity to establish how the Government and local commissioners can take things forward. It is imperative that the NHS has the best possible culture for how staff are treated and heard. I hope she will look at the announcement made by my right hon. Friend the Secretary of State about ensuring that people have the freedom to speak up and safe spaces in which to blow the whistle.

22 Mar 2016 | Topical questions - Supplementary | 607 c1374

Topical Questions

Asked by: Rosie Cooper

At Prime Minister's questions in February 2014, I raised with the Prime Minister my very serious concerns about the dangerous bullying culture at Liverpool Community Health NHS Trust. I understand that the Capsticks inquiry into parts of that is now complete, so will the Secretary of State, in the spirit of honouring his stated commitment to openness and transparency, ensure

that that report is made available, perhaps via the NHS Trust Development Authority, if necessary, to the public trust board on 23 February?

Oral questions - 1st Supplementary

Answering member: Mr Hunt

I will happily look into that matter. The Under-Secretary of State for Health, my hon. Friend the Member for Ipswich (Ben Gummer), has held a round table on bullying and harassment. I thank the hon. Lady for raising the issue, because over the past decade—none of us should be proud of this—the number of NHS staff who say they are suffering from bullying and harassment has gone up from 14% to 22%. If we are going to deliver safer care, we have to make it easier for doctors and nurses on the frontline to speak out without worrying about being bullied or harassed.

09 Feb 2016 | Oral answers to questions | 605 c1434

Liverpool Prison: Health Services

Asked by: Baroness Stern

To ask Her Majesty's Government, following the finding in 2014 by the Care Quality Commission that healthcare provision in HM Prison Liverpool was unsafe and the October report by Her Majesty's Chief Inspector of Prisons on HM Prison Liverpool that improvement in

healthcare "had a long way to go", when they expect that prison to provide an acceptable level of healthcare.

Answering member: Baroness Evans of Bowes Park

Action is currently being taken to address the recommendations made in the inspection report.

That includes working closely with Lancashire Care NHS Trust to improve the healthcare provision, which includes the recruitment of appropriate skilled healthcare professionals and robust data management collection.

The inpatient facility now operates a structured daily regime for in patients and the holistic approach by the multi-disciplinary team which includes service user forums, psychiatric sessions and care plan reviews provides an enhanced care package.

10 Nov 2015 | Written questions | HL3113

4.2 Written Statements

Made by Jeremy Hunt (The Secretary of State)

NHS Learning Culture

I would like to inform the House of the steps the Government is taking to make the NHS the safest healthcare system in the world. Perhaps the single most important thing we can do is to create a learning rather than a blame culture, so that clinicians feel supported to speak out when things go wrong.

NHS Improvement is today publishing a Learning from Mistakes League. This draws on data from the staff survey and safety reporting data to set out a league table for NHS provider organisations. This will provide information to the providers themselves as well as to the wider public about how well different organisations are learning, and how open and honest they are. The information in the League will be published on an annual basis as part of the CQC's report on hospital care quality.

Later this month, the NHS Improvement will also publish estimates by Trust of avoidable mortality, and information relating to this will then be published as part of an annual CQC report on care quality in hospitals.

In addition to greater and more intelligent transparency, a culture of learning means we need to create an environment in which clinicians feel able to speak up about mistakes. We will therefore bring forward measures for those who speak honestly to investigators from the Healthcare Safety Investigation Branch to have the kind of 'safe space' that applies to those speaking to the Air Accident Investigation Branch.

The General Medical Council and the Nursing and Midwifery Council have made it clear through their guidance that where doctors, nurses or midwives admit what has gone wrong and apologise, the professional tribunal should give them credit for that, just as failing to do so is likely to incur a serious sanction. The government remains committed to legal

reform that would allow professional regulators more flexibility to resolve cases without stressful tribunals.

NHS Improvement will ask for the commitment to learning to be reflected in all Trust disciplinary procedures and ask all Trusts to publish a Charter for Openness and Transparency so staff can have clear expectations of how they will be treated if they witness clinical errors.

From April 2018, the Government will introduce the system of medical examiners recommended in the Francis Report. This will bring a profound change in our ability to learn from unexpected or avoidable deaths, with every death either investigated by a coroner or scrutinised by a second independent doctor. Grieving relatives will be at the heart of the process and will have the chance to flag any concerns about the quality of care and cause of death with the independent clinician.

NHS England is working with the Royal College of Physicians to develop and roll-out across the NHS a standardised method for reviewing the records of patients who have died in hospital.

These measures, along with the professionalism and dedication of NHS staff will help the NHS to achieve its aim of becoming the world's largest learning organisation

HC WS582 09 Mar 2016

Made by: Mr Jeremy Hunt (The Secretary of State for Health)

Publication of Learning Not Blaming and Review of NHS Leadership

I have published today "Learning not blaming" (CM9113), which sets out the Government's position on the Freedom to Speak Up Consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and Dr Bill Kirkup's independent report on the Morecambe Bay Investigation; and, in a separate document, Lord Rose's report on NHS leadership.

The three reports cover distinct areas, and the accompanying document addresses the points and recommendations raised in each report. The 'Freedom to Speak Up' review by Sir Robert Francis QC, focused on whistleblowing; the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS'; and, the investigation into University Hospitals Morecambe Bay NHS Foundation Trust, conducted by Dr Bill Kirkup CBE. There are, however, some themes common to each report, including the importance of:

- openness, honesty and candour;
- listening to patients, families and staff;
- finding and facing the truth;
- learning from errors and failures in care;
- people and professionalism.

In considering points made in these reports, the Government have been guided by the need to build on the work we and the NHS have done in recent years to improve the way in which the NHS treats patients and families, by developing capabilities locally to respond to patients' and families' concerns and to exercise proper oversight of care quality.

In recognition of this, the NHS's own Five Year Forward View emphasises the need for care to be both safe and sustainable over the long term. For each of the reports, we therefore propose specific actions to address the immediate issues they raise, and in doing so make clear that the NHS must develop an improved approach to patient safety and complaints. Our response therefore sets out a strong expectation that we want nothing less than a renewed culture that values learning, not blaming; compassion, not defensiveness; and putting patients and families before systems and institutions.

In summary, we will:

- put in place Freedom to Speak Up Guardians in each Trust to build up capability and capacity locally, at the frontline of service provision;
- ensure that every local NHS provider provides training in raising and listening to concerns;
- remove the Nursing and Midwifery Council's current responsibility and accountability for statutory supervision of midwives in the United Kingdom. (The NMC will of course remain responsible for the regulation of midwifery, but the supervision of midwives will be brought into line with the arrangements for other clinical professions);
- review the Professional Codes of doctors, nurses and midwives and ensure that the right incentives are in place to encourage people to report openly, and to learn from mistakes;
- set up a new patient safety investigation function to be fully operational from 1 April 2016 – the Independent Patient Safety Investigation Service. An Expert Advisory Group will convene shortly in order to develop the structure, governance and operating model of this new service.

Freedom to Speak Up

The Government has consulted on a package of measures to implement the principles and actions set out in Sir Robert Francis QC's report. In light of the consultation responses, I can now announce that the role of Independent National Officer will be hosted by the Care Quality Commission, who intend to have them in place by December 2015. I can also announce that Freedom to Speak Up Guardians will be appointed in all NHS Trusts, to build up capability and capacity locally, at the frontline of service provision, following guidance published by the Independent National Officer.

Robert's report also called for training on raising and hearing concerns in every local NHS provider organisation. The relevant national bodies will now be working on a package that would include the following content:

- the inclusion of content on raising concerns in induction training for all staff;
- the inclusion of good practice regarding the raising of concerns for healthcare professionals as part of their professional codes, followed up through continuing professional development;
- the regular use of reflective practice, through for example team meetings or Schwartz rounds, to review particular examples when

concerns have been raised or not raised and how this might be improved in future;
- the inclusion of content on raising concerns in other specific packages of training that NHS workers are expected to undertake or which NHS employers have included in annual training priorities; and
- the inclusion of content on raising concerns in initial education and training undertaken by those learning to become healthcare professionals. This is already being considered and developed by Health Education England.

Morecambe Bay Investigation

The Government have accepted all of the recommendations of this report.

The recommendation for an Independent Patient Safety Investigation Service is explained in more detail in our response to the Public Administration Select Committee report.

We will use secondary legislation to remove the Nursing and Midwifery Council's current responsibility and accountability for statutory supervision of midwives in the United Kingdom. The NMC will of course remain responsible for the regulation of midwifery, but the supervision of midwives will be brought into line with the arrangements for other clinical professions. This will improve the local oversight and accountability for midwifery. Existing arrangements will remain in place until alternative arrangements are introduced.

In addition, I have asked Professor Sir Bruce Keogh to review the Professional Codes for all regulated staff in the NHS and to ensure that the right incentives are in place to encourage reporting and learning from mistakes, and prevent covering up.

In response to recommendations 25 and 42 in the Report, I am proposing to review the regulations that set out statutory requirements for notifications to the Care Quality Commission and Monitor during 2015-16 with the intention of addressing Dr Kirkup's recommendation that Trust boards should openly report the findings of any reviews of care to relevant external bodies. We would also like to extend this to the commissioning of any such reviews. We will consult on any changes.

In response to recommendation 20, NHS England has established a national review of maternity services, independently chaired by Baroness Cumberlege. It is anticipated that the Review will publish proposals on safe and efficient models of maternity care at the end of the year. The review will pay particular attention to the challenges of achieving this objective in more geographically isolated areas.

Public Administration Select Committee report

We accept the recommendations of this report.

Our response sets out the Government's decision to set up a new Independent Patient Safety Investigation Service, to be operational from 1 April 2016. IPSIS will operate independently and it will be brought

under the single leadership of Monitor and the NHS Trust Development Authority.

We have also set up an Expert Advisory Group to advise on the scope, governance and operating model of this new service. The membership of this Group includes:

- Dr Mike Durkin, National Director for Patient Safety
- Keith Conradi, Chief Inspector of the Air Accidents Investigations Branch
- James Titcombe OBE, Morecambe Bay campaigner and currently working as a patient safety adviser to CQC
- Prof Jonathan Montgomery, Professor of Healthcare Law at University College London
- Julian Brookes, advisor on clinical governance for the Morecambe Bay Investigation, deputy chief operating officer Public Health England
- Carl Macrae, Independent Quality Improvement Expert
- Prof Martin Marshall CBE, Professor of Healthcare Improvement at University College London
- Dame Eileen Sills DBE, Chief Nurse and Director of Patient Experience, Guy's and St Thomas' NHS Trust
- Dr Bill Kirkup CBE, Chairman of the Morecambe Bay Investigation
- Kate Lampard CBE, barrister and NHS strategic health authority chairman who provided oversight on the NHS's Savile investigations.

PASC also recommended that, "draft legislation should be published for scrutiny early in the next Parliament" as part of the establishment of this new function. We will ask the expert group to consider whether the work of the Independent Patient Safety Investigation Service would benefit from having any legal powers to fulfil its duties effectively.

I am confident that the new service will help to transform the state of patient safety.

Rose

I have today also published the report of Lord Rose's review of National Health Service (NHS) Leadership, "Better leadership for tomorrow". A copy is attached. This is an important report making recommendations for the creation of a single NHS vision, improving training, performance management, reducing bureaucracy and improving management support.

I asked Lord Rose early in 2014 to consider what might be done to attract and develop talent from inside and outside the health sector into leading positions in the NHS and to recommend how strong leadership in hospital Trusts might help transform the way things get done. Following the publication of the NHS's Five Year Forward View, I requested him to extend his remit to consider how best to equip Clinical Commissioning Groups to deliver the vision outlined within that report.

I welcome Lord Rose's report and his nineteen recommendations, all of which I have accepted in principle.

I am announcing today that the Government accepts fully the recommendation to transfer responsibility for the NHS Leadership Academy from NHS England to Health Education England (HEE).

The Government also accepts the need to do more to manage talent in the NHS and I can announce today that talent management for our brightest and best will become a formal responsibility for the single leadership of Monitor and the NHS Trust Development Authority.

My Department will work with the Health and Care system to develop plans to implement each of the other recommendations to the extent possible, subject to an assessment of proportionality, cost-effectiveness and affordability.

Better Leadership for Tomorrow, Lord Rose (PDF Document, 440.55 KB)

HCWS113 16 July 2016

4.3 Debate

NHS: Learning from Mistakes

HC Deb 09 Mar 2016 607 cc295-310

5. Further reading

CQC, Liverpool Community Health NHS Trust Quality Report,

July 2016

Liverpool Community Health NHS Trust, Capsticks Solicitors LLP Governance Consultancy Service,

Quality, safety and management assurance review at Liverpool Community Health NHS Trust,

22 March 2016

Library Briefing Paper,

NHS whistleblowing procedures in England,

September 2015

DEBATE PACK
Number CDP 2016-0144
12 July 2016

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