

Learning the lessons: the RCN response to the Bristol Royal Infirmary Inquiry

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The Royal College of Nursing

With a membership of over a third of a million, the RCN is the largest professional association and union of nursing staff and students in the UK. As such, it is an influential voice for nursing at home and abroad. The RCN promotes nursing interests on a wide range of issues by working closely with the Government, parliament, unions, professional bodies and voluntary organisations.

The RCN campaigns on behalf of its members and the people they care for, and is a leading player in the development of nursing policy and practice, and standards of care. It provides a comprehensive range of services and benefits for its members, including: advice and support on a range of clinical and employment issues; the foremost nursing library in Europe; and RCN Direct, the 24 hour telephone information and advice service for members. The RCN also provides continuing professional development opportunities through its distance learning and short course programme, and promotes research, quality and practice development through the RCN Institute.

Learning the lessons: the RCN response to the Bristol Royal Infirmary Inquiry

The RCN was very pleased to be so closely involved in the Bristol Royal Infirmary Inquiry. From the outset, it was clear that this Inquiry was going to concentrate on a wide range review of the NHS in England. The RCN provided evidence to the Inquiry by way of a major paper in part one, and a series of seminar papers in part two. The RCN was delighted that the Committee made such use of the seminar paper, *Empowering the public in the health care process* in forming their Recommendations.

The RCN fully endorses the main focus of the Report. This places patients, including children and the public at the heart of health service planning and provision. What is now needed is specific guidance on how the recommendations can be implemented. This will be crucial to the success of public involvement.

Many of the recommendations urge a significant cultural change with the NHS, with a strong shift in focus so that the patient is at the heart of health care delivery. RCN policy development and research has highlighted some of the processes needed to make that cultural change.

There is a lot in the Report and in the Recommendations. We want all nurses and midwives to use this document in a practical way. There are suggestions made at the back of the document about ways that you can use this document in your workplace. The report is so wide ranging that we do not want you to take all the Recommendations on in one go. We suggest that, to begin with, you look for the areas that fit your workplace and your nursing interests most closely. Read the section with the Recommendations and look at the RCN comments. Discuss with your colleagues how you can make a change and what work you want the RCN to do on your behalf to help you make those changes.

We have set up a page on the RCN website where you can give us your feedback on the ways that you are seeing a difference from this Report. This is your document, and we welcome your feedback on it.

**Royal College of Nursing
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The Recommendations

Section 1: Respect and honesty

Partnership: involving patients

1 In a patient-centred health care service patients must be involved, wherever possible, in decisions about their treatment and care.

2 The education and training of all health care professionals should be imbued with the idea of partnership between the health care professional and the patient.

3 The notion of partnership between the health care professional and the patient, whereby the patient and the professional meet as equals with different expertise, must be adopted by health care professionals in all parts of the NHS, including health care professionals in hospitals.

Patients should be at the heart of health care. The Kennedy Report exposes how competing interests often mean that this fundamental value in the health service is lost. Nurses are one of the key professional groups who can ensure that the patient is at the heart of the health service.

Nurses need to highlight the importance of partnership working with patients, and this involves active participation by nurses. Partnership involves rights for patients and obligations for practitioners. Developing partnerships with patients takes place on a daily basis. This requires not only expert communication skills from the nurse but also space for the nurse to develop rapport in demanding clinical settings. It requires time for the nurse to see the world through the patient's eyes, and to understand their fears and confusion.

Nurses need space to provide patient-centred care. This space allows nurses to develop effective strategies to keep the patient at the heart of the health service. Nurses require access to clinical supervision and, with this space, nurses will be in a stronger position to challenge barriers in their workplace which do not place the patient at the heart of the health service.

Placing the patient at the heart of the health service requires a workplace culture of effectiveness. This allows nurses to challenge systems that do not allow a relationship of partnership with patients. A culture in which the patient is at the heart of the service is a culture that nurtures and values different groups with different status. The RCN recommends the development of formal systems of participation, which reflect patient-centred values where all stakeholders are valued and engaged equally.

The values of honesty and respect are fundamental core values for nurses. The RCN Clinical Leadership Programme is one example of the RCN taking this forward. Local facilitators are encouraged to consider these values in relation to patients and their families. Through the experience of a learning community, these values are further developed in small groups. These clinical leaders are supported in developing their teams in similar ways. Honesty and respect is demonstrated through action learning, programme

interventions, mentoring, and one-to-one development sessions. The Clinical Leadership Programme places a focus on these values so the nurses will take their learning back to the work place and continue to influence their relationships with patients, relatives and carers.

Keeping patients informed about treatment and care

4 Information about treatment and care should be given in a variety of forms, be given in stages and be reinforced over time.

5 Information should be tailored to the needs, circumstances and wishes of the individual.

6 Information should be based on the current available evidence and should include a summary of the evidence and data, in a form which is comprehensible to patients.

7 Various modes of conveying information, whether leaflets, tapes, videos or CDs, should be regularly updated, and developed and piloted with the help of patients.

8 The NHS Modernisation Agency should make the improvement of the quality of information for patients a priority. In relation to the content and the dissemination of information for patients, the Agency should identify and promote good practice throughout the NHS. It should establish a system for accrediting materials intended to inform patients.

9 The public should receive guidance on those sources of information about health and health care on the Internet which are reliable and of good quality: a kitemarking system should be developed.

One of the most transparent ways of ensuring that the patient is at the heart of the health service is to give information. The RCN believes this is crucial to maintaining trust between patients and nursing staff. Studies by the RCN using evidence in practice demonstrate the value of using evidence drawn from the patient's own preferences. This is a core attribute of keeping the patient at the centre of health care delivery.

Information should be shared with patients so that they have the best opportunity to make decisions about their health care. The provision of information to patients requires effective strategies by nursing staff. Nurses have the ability to organise care in a way that ensures that nurses get to know their patients as individuals. Sufficient time is needed for this. Expertise in communications is also needed in a range of different interventions that can be provided from other team members.

The RCN has its own programme of guideline work. Current work includes working with patients and producing evidence based patient information such as patient versions of the leg ulcer, children's pain and pressure ulcer guidelines. For the children's pain guideline, the RCN collected evidence from children to inform the evidence base of the guideline and produced a children's version of the guideline recommendations in a cartoon format. The RCN is currently developing and piloting audit tools that children and their parents can use to evaluate the quality of care against the guideline recommendation.

In providing accessible material to patients, it is important to use language which enables complex concepts and technical information to be presented in a user-friendly way. The RCN agrees that the improvement of the quality of information for patients is a priority. A kitemarking system will help patients in the way that tapes, videos, CDs and leaflets are created. The RCN suggests that one possible approach would be the use of a quality system such as DISCERN to judge the quality of information.

The RCN endorses the need for material to be accredited for quality in the use of English, other languages, user-friendliness and presentation. Such materials must be developed in partnership with patients. The RCN provides its own accreditation service for such educational products.

Communicating with patients

10 *Tape-recording facilities should be provided by the NHS to enable patients, should they so wish, to make a tape recording of a discussion with a health care professional when a diagnosis, course of treatment, or prognosis is being discussed.*

11 *Patients should always be given the opportunity and time to ask questions about what they are told, to seek clarification and to ask for more information. It must be the responsibility of employers in the NHS to ensure that the working arrangements of health care professionals allow for this, not least that they have the necessary time.*

12 *Patients must be given information to enable them to participate in their care.*

13 *Before embarking on any procedure, patients should be given an explanation of what is going to happen and, after the procedure, should have the opportunity to review what has happened.*

14 *Patients should be supported in dealing with the additional anxiety sometimes created by greater knowledge.*

15 *Patients should be told that they may have another person of their choosing present when receiving information about a diagnosis or a procedure.*

16 *Patients should be given the sense of freedom to indicate when they do not want any (or more) information: this requires skill and understanding from health care professionals.*

17 *Patients should receive a copy of any letter written about their care or treatment by one health care professional to another.*

18 *Parents of those too young to take decisions for themselves should receive a copy of any letter written by one health care professional to another about their child's treatment or care.*

19 *Health care professionals responsible for the care of any particular patient must communicate effectively with each other. The aim must be to avoid giving the patient conflicting advice and information.*

Communication with patients is central to changing the culture of respect and honesty in the health service. Good communication takes time. It is important that nurses have time to communicate well with patients. Having enough time to spend with patients should not be viewed as a luxury: it is a central component of nursing care. Sufficient skill mix and staffing levels are needed so that this central part of health care is not compromised. The RCN knows

that skill mix in many settings is out of balance: too few senior and experienced staff are available. The NHS is now taking workforce planning more seriously and an assessment of communication time and skill should be part of this planning process.

Effective communication within the health care team is not a luxury. Nurses who are unsure that their communication is effective must be encouraged to take positive action. This is an essential, not an ideal.

Effective communication with patients has been demonstrated within the RCN's Expertise in Practice Project. The project demonstrates 'how' patients are communicated with. It also assesses whether patients feel in control of their own decisions. The multidisciplinary teams in which these experts worked demonstrated open, direct and honest communication with a focus on meeting patients needs.

Within the RCN Quality Improvement Programme, a current research programme is looking to validate an American quality indicator (the Perceptions of Unit Quality Scale, developed by Professor Linda Cronewett of Chapel Hill University). Research in the USA suggests a significant relationship between perceptions of quality and influences of richer skill mix and greater nursing involvement in decision making.

The RCN agrees that there should be full disclosure of health care letters to patients. This will increase the confidence that patients have in the care that they are given. Where patients have access to high quality and transparent health care this will ensure that the patient is at the heart of health care. The RCN is aware for example that many of the consultations between parents, staff and children at Birmingham Children's Hospital are recorded and the family is given a copy to take home

Support services for patients

20 *The provision of counselling and support should be regarded as an integral part of a patient's care. All hospital trusts should have a well-developed system and a well-trained group of professionals whose task it is to provide this type of support and to make links to the various other forms of support (such as that provided by voluntary or social services) which patients may need.*

21 *Every trust should have a professional bereavement service. (We also reiterate what was recommended in the Inquiry's Interim Report: 'Recommendation 13: As hospitals develop websites, a domain should be created concerned with bereavement in which all the relevant information concerning post-mortems can be set out in an appropriate manner.')*

22 *Voluntary organisations which provide care and support to patients and carers in the NHS (such as through telephone helplines, the provision of information and the organisation of self-help groups) play a very important role. Groups which meet the appropriate standards as laid down by the NHS should receive appropriate funding from the state for the contribution they make to the NHS.*

The RCN was delighted that the Child Bereavement Trust was launched at the RCN by the Princess of Wales. The RCN believes that for these

recommendations to be implemented, the Department of Health could provide core funding for projects to relieve the pressure on hospitals to spend time fund raising for this important work. The RCN currently works alongside a wide range of organisations in providing assistance.

The RCN has also been involved with the Confidential Enquiry in Deaths and Stillbirth in Infants (CEDSI) in their information leaflets for parents on consent to post mortem.

Consent to treatment

23 We note and endorse the recent statement on consent produced by the DoH: 'Reference guide to consent for examination or treatment', 2001. It should inform the practice of all health care professionals in the NHS and be introduced into practice in all trusts.

24 The process of informing the patient, and obtaining consent to a course of treatment, should be regarded as a process and not a one-off event consisting of obtaining a patient's signature on a form.

25 The process of consent should apply not only to surgical procedures but to all clinical procedures and examinations which involve any form of touching. This must not mean more forms: it means more communication.

26 As part of the process of obtaining consent, except when they have indicated otherwise, patients should be given sufficient information about what is to take place, the risks, uncertainties, and possible negative consequences of the proposed treatment, about any alternatives and about the likely outcome, to enable them to make a choice about how to proceed.

27 Patients should be referred to information relating to the performance of the trust, of the specialty and of the consultant unit (a consultant and the team of doctors who work under his or her supervision). (See further the Recommendations on care of an appropriate standard.)

The RCN encourages nurses to see consent as a process that involves an ongoing dialogue rather than a static process of obtaining a signature. The RCN Expertise in Practice Project focuses on obtaining patients consent at every stage of the process, whether that is the care or research process

The Department of Health in England has a Good Practice in Consent Advisory Group. The RCN welcomes the approach taken by this group for wide spread dissemination of the advice on consent. The RCN welcomes that the short 12 point plan has been sent to all registered nurses on the UKCC register. The Advisory Group has further work planned on the consent form and some information leaflets have also been recently published. The RCN welcomes the involvement of nurses in this ongoing work.

The need for consent throughout every encounter between practitioner and patient is crucial. The value of a health care relationship as an ongoing enterprise is endorsed by the RCN.

The RCN Millennium Nurse of the Year, Gill Brook, was commended for her work with children and young people with life threatening illnesses. She promoted consent as a major part of her work.

Feedback from patients

28 *Patients must be given the opportunity to pass on views on the service which they have received: all parts of the NHS should routinely seek and act on feedback from patients as to their views of the service. In addition, formal, systematic structured surveys of patients' experience of their care (not merely satisfaction surveys) should be routinely conducted across the NHS and the results made public.*

29 *NHS trusts and primary care trusts must have systems which ensure that patients know where and to whom to go when they need further information or explanation.*

30 *We endorse the initiative in 'The NHS Plan' to establish a Patient Advocacy and Liaison Service in every NHS trust and primary care trust. The establishment of this service should be implemented in full as quickly as possible. Once established, patient advocacy and liaison services must be given secure funding to enable them to provide an effective service to patients.*

31 *Trusts and primary care trusts must have systems for publishing periodic reports on patients' views and suggestions, including information about the action taken in the light of them. (See further the Recommendations on care of an appropriate standard.)*

32 *So as to provide for patients an effective, efficient and seamless information and advocacy service, consideration should be given to how the various patient advocacy and liaison services in a given geographical area could most effectively collaborate, including in relation to the provision of information for patients and the public.*

Obtaining genuine feedback from the patient can only take place where the patient is valued as a genuine partner in care. This must be more than tokenism. This feedback should be used to provide qualitative data to make genuine improvements in the health service. One issue from feedback is the boundary between quality improvement and research. The RCN believes this needs to be addressed by the health service. All processes used to obtain feedback should be transparent and open to ethical scrutiny.

It is particularly important that impact of the views and experiences of patients and the public is clearly and publicly documented. This has been an area of weakness in the past and has often led to criticisms by patient and consumer groups. Catherine Baraniak, lead nurse of the primary medical services pilot in Derby has a particularly successful patient/staff forum. This has a validated system for receiving the views and comments from the patients.

The RCN fully endorses the need to seek and act on feedback from patients. Qualitative approaches can complement the survey approach by providing a deeper and more insightful understanding of the patient's health care experience. These approaches can often provide a platform on which to build surveys. The RCN Institute is carrying out a range of studies to extend understanding of the way patients make judgements about their care. This can assist methodological development that measures outcome in a more meaningful way for patients.

Most of the research which has examined patients experiences and evaluated their care has focused on adults. Very little work has focused on children's experiences. In recognition of this the RCN and Action For Sick Children have

carried out a study which explored experiences of pain. Future studies should continue to consider how children could be involved in their care.

Responding to the patient when things go wrong

33 *A duty of candour, meaning a duty to tell a patient if adverse events have occurred, must be recognised as owed by all those working in the NHS to patients.*

34 *When things go wrong, patients are entitled to receive an acknowledgement, an explanation and an apology.*

35 *There should be a clear system, in the form of a 'one-stop shop' in every trust, for addressing the concerns of a patient about the care provided by, or the conduct of, a health care professional.*

36 *Complaints should be dealt with swiftly and thoroughly, keeping the patient (and carer) informed. There should be a strong independent element, not part of the trust's management or board, in any body considering serious complaints which require formal investigation. An independent advocacy service should be established to assist patients (and carers).*

37 *There should be an urgent review of the system for providing compensation to those who suffer harm arising out of medical care. The review should be concerned with the introduction of an administrative system for responding promptly to patients' needs in place of the current system of clinical negligence and should take account of other administrative systems for meeting the financial needs of the public.*

The RCN endorses the view that respect and honesty has to include a duty of honesty when things go wrong. Prompt disclosure is a priority. There is also a need for mechanisms to be created so that shared learning from mistakes can be a characteristic of a learning culture. Openness and transparency will reflect these values, resulting in trust between health care professionals and patients, carers and families.

The RCN is aware of the legal difficulties that may exist for a duty of honesty to be incorporated in a contract of employment. This needs to be part of a comprehensive review of the whole issue of legal liability for clinical errors. The RCN is part of the Chief Medical Officer's review of clinical negligence in England and will be consulting on the proposals with members.

Section 2: A well led health service

38 The Department of Health's roles in relation to the NHS must in future be made explicit. The DoH should have two roles. It should be the headquarters of the NHS. It should also establish an independent framework of regulation which will assure the quality of the care provided in and funded by the NHS, and the competence of health care professionals.

The regulation of the quality and safety of health care

39 The framework of regulation must consist of two overarching organisations, independent of government, which bring together the various bodies which regulate health care. A Council for the Quality of Health care should be created to bring together those bodies which regulate health care standards and institutions (including, for example, the Commission for Health Improvement (CHI), the National Institute for Clinical Excellence (NICE) and the proposed National Patient Safety Agency). A Council for the Regulation of Health care Professionals should be created to bring together those bodies which regulate health care professionals (including, for example, the General Medical Council (GMC) and the Nursing and Midwifery Council); in effect, this is the body currently referred to in 'The NHS Plan' as the Council of Health care Regulators. These overarching organisations must ensure that there is an integrated and co-ordinated approach to setting standards, monitoring performance, and inspection and validation. Issues of overlap and of gaps between the various bodies must be addressed and resolved.

40 The two Councils should be independent of government and report both to the DoH and to Parliament. There should be close collaboration between the two Councils. The DoH should establish and fund the Councils and set their strategic framework, and thereafter periodically review them.

41 The various bodies whose purpose it is to assure the quality of care in the NHS (for example, CHI and NICE) and the competence of health care professionals (for example, the GMC and the Nursing and Midwifery Council) must themselves be independent of and at arm's-length from the DoH.

42 All the various bodies and organisations concerned with regulation, besides being independent of government, must involve and reflect the interests of patients, the public and health care professionals, as well as the NHS and government.

The RCN approves of the proposal to consolidate the various bodies charged with regulation of health care standards and institutions. The RCN welcomes the Government's commitment to establish a UK Council for Health Regulators to cover the various bodies that currently exist.

The RCN has undertaken joint activity with other Royal Colleges and the Medical Devices Agency in the production of standards to assist in the regulation of the quality and safety of health care.

The RCN is concerned that there are no proposals to regulate health care assistants. The RCN believes that health care assistants should be regulated across the UK by the Nursing and Midwifery Council. The RCN believes that this is the most appropriate means to ensure that there is consistency in approach of the regulatory arrangements across the UK in the best interests of patients.

The management of the NHS at the local level

Contractual relations between trusts and employees

43 *The contractual relationship between trusts and consultants should be redefined. The trust must provide the consultant with the time, space and the necessary tools to do the job. Consultants must accept that the time spent in the hospital and what they do in that time must be explicitly set out.*

44 *The system of Distinction Awards for hospital consultants should be examined to determine whether it could be used to provide greater incentives than exist at present for providing good quality of care to patients. The possibility of its extension to include junior hospital doctors should be explored.*

45 *The doctors' Code of Professional Practice, as set down in the GMC's 'Good Medical Practice', should be incorporated into the contract of employment between doctors and trusts. In the case of GPs, the terms of service should be amended to incorporate the Code.*

46 *The relevant codes of practice for nurses, for professions allied to medicine and for managers should be incorporated into their contracts of employment with hospital trusts or primary care trusts.*

47 *Trusts should be able to deal as employers with breaches of the relevant professional code by a health care professional, independently of any action which the relevant professional body may take.*

The RCN recognises the need to consider the contractual relationship between staff and the NHS. The RCN is part of the negotiating body for the Agenda for Change project which is reviewing terms and conditions of employment contracts for nurses.

The RCN does not agree that the regulatory Code of Conduct should be incorporated into contracts of employment for nurses and doctors. The RCN believes that this has the potential to confuse the relationship between the employer and the regulatory body. This does not appear in keeping with the recommendations that the operational and regulatory arrangements in the NHS are separated.

The RCN does not agree that employers should be able to use the Code of Conduct as a disciplinary tool. The potential for confusion is clear: if an employer decides that there has been a breach of the Code, and the regulatory body does not, the scope for confusion about interpretation of the various Codes becomes difficult for staff. The RCN believes that the role of the regulatory bodies needs to be made explicit and that they should not handle local disciplinary issues but should handle issues about whether a nurses is fit to remain on the register.

The chief executive and senior management

48 *The security of tenure of the chief executive and senior managers of trusts should be on a par with that of other senior professionals in the NHS.*

The trust board

49 *The criteria and process for selection of the executive directors of a trust board must be open and transparent. Appointments should be made on the basis of ability and not on the basis of seniority.*

50 *The NHS Leadership Centre, in conjunction with trusts, should develop programmes of training and support for clinicians and others who seek to become executive directors.*

51 *As recommended in 'The NHS Plan', there should be an NHS Appointments Commission responsible for the appointment of non-executive directors of NHS trusts, health authorities and primary care trusts.*

52 *Newly appointed non-executive directors of trusts, health authorities and primary care trusts should receive a programme of induction: this should refer to the principles and values of the NHS and their duties and responsibilities with regard to the quality of care provided by the trust. This programme should be provided through the NHS Leadership Centre.*

53 *A standard job description should be developed by the NHS for non-executive directors, as proposed in 'The NHS Plan'.*

54 *Throughout their period of tenure, non-executive directors should be provided with training, support and advice organised and co-ordinated through the NHS Leadership Centre.*

55 *The Chairs of trust boards should have a source of independent advice (or mentor) during their period of office, drawn from a pool of experts assembled by the NHS Leadership Centre.*

56 *Arrangements should be in place in the standing orders of trust boards to provide for proper continuity in the management of the trust's affairs in the period between the cessation of the Chair's term of office and the commencement of that of a successor.*

Section 3: Competent health care professionals

Broadening the notion of professional competence

57 Greater priority than at present should be given to non-clinical aspects of care in six key areas in the education, training and continuing professional development of health care professionals: skills in communicating with patients and with colleagues; education about the principles and organisation of the NHS, and about how care is managed, and the skills required for management; the development of teamwork; shared learning across professional boundaries; clinical audit and reflective practice; and leadership.

58 Competence in non-clinical aspects of caring for patients should be formally assessed as part of the process of obtaining an initial professional qualification, whether as a doctor, a nurse or some other health care professional.

59 Education in communication skills must be an essential part of the education of all health care professionals. Communication skills include the ability to engage with patients on an emotional level, to listen, to assess how much information a patient wants to know, and to convey information with clarity and sympathy.

60 Communication skills must also include the ability to engage with and respect the views of fellow health care professionals.

61 The education, training and Continuing Professional Development (CPD) of all health care professionals should include joint courses between the professions.

62 There should be more opportunities than at present for multi-professional teams to learn, train and develop together.

63 All those preparing for a career in clinical care should receive some education in the management of health care, the health service and the skills required for management.

64 Greater opportunities should be created for managers and clinicians to 'shadow' one another for short periods to learn about their respective roles and work pressures.

Skills in communications are central to effective nursing and health care. The RCN believes that clinical audit should be taught alongside other key areas such as managing risk and improving patient safety.

Joint training among professionals is also valuable to ensuring that a "them and us" culture is avoided. The RCN believes that this should happen at pre registration and post registration.

The RCN anticipates that the Primary Care Trusts and Care in England have the potential as new organisations to encourage more open relationships between managers and clinicians. This should be a central part of the set up arrangements.

The recognition of the importance of non-clinical aspects of competence is welcome. The RCN's UK-wide study of expertise in nursing practice demonstrates the impact of combining these skills in achieving effective relationships with patients. This leads to relationships where patients feel cared for and can trust the practitioner. The RCN study also shows that combining technical and non-technical skills is central to expertise in practice and prevents patients from being 'lost' in the system.

The need to address these non clinical aspects of care at a pre registration level is strongly reinforced by RCN feedback from annual focus groups on clinical governance with RCN members.

Lack of teamwork acts as a significant barrier to the implementation of clinical governance. There are issues that need to be seen as integral to professional practice, and not optional extras in educational curricula.

Health care professionals need to develop a culture of critique where mutual challenge, support and self-critique are characteristics of transparent decision-making. RCN studies demonstrate that such systems have an impact on workplace culture, where sustainable change, patient-centred care and services have been achieved.

Practice development can transform the culture of care. This can help practitioners to develop their skills and use these directly in practice. For these to be successful, there must be matching support at the strategic and organisational interfaces.

Management skills at all levels must involve constant monitoring of a changing health care context. The development of effective teams is central to developing a learning culture. Shared learning must involve all members of the team. This is a powerful mechanism for developing a common vision about how change can be achieved. Where values and beliefs match those experienced in practice, an effective workplace culture is created.

The ability to engage with the patient at an emotional level requires that practitioners develop emotional competence and understand the role and impact of emotional labour on themselves, others and patients. It is vital to ensure that supportive mechanisms and systems are available to help practitioners become more effective in this area.

The RCN agrees that competence in non-technical aspects of caring should be formally assessed. Pre-registration nurse education programmes comprise 50% theory and 50% practice, enabling assessment of skills such as communication and teamwork in both settings. The role of facilitation and the importance of a 'helping relationship' within the context of professional supervision is an important part of the RCN's practice development initiatives. Practitioners are helped to become more effective. They can change the practice culture to one that is patient-centred and evidence-based.

The RCN supports the need for more opportunities for learning, training and developing together. The RCN believes that these opportunities should be an integral part of staff development strategies.

The RCN supports the development of management and leadership skills throughout all stages of education and training. Inherent in this is the development of competent problem-solving and decision-making skills, which are a vital part of a health professional's craft. The RCN would like to see

them more explicitly addressed in both pre and post-graduate education and training.

Leadership: skills and capacity

65 An early priority for the new NHS Leadership Centre should be to offer guidelines as to leadership styles and practices which are acceptable and to be encouraged within the NHS, and those which are not.

66 Steps should be taken to identify and train those within the NHS who have the potential to exercise leadership. There needs to be a sustained investment in developing leadership skills at all levels in the NHS.

67 The NHS's investment in developing and funding programmes in leadership skills should be focused on supporting joint education and multi-professional training, open to nurses, doctors, managers and other health care professionals.

68 The NHS Leadership Centre should be involved in all stages of the education, training and continuing development of all health care professionals.

The RCN agrees that it is vital to focus on the role of leadership in a changing workplace culture. It is also important to recognise the role of the Human Resource Departments in highlighting organisational values and beliefs.

The RCN suggests that the NHS Leadership Centre draws on available expertise from clinical practice, professional bodies and management schools. A strategy for the work of the Leadership Centre needs to be developed involving other key stakeholders.

Developing the leadership potential of others is an essential requisite for all team leaders and a characteristic of transformational leadership. The RCN suggests an approach to developing leaders that involves talent-spotting at all levels of the health service. Offering leadership development programmes to all staff would be an opportunity for those who may not be recognised initially as having talent to shine. Experiences from all RCN leadership programmes support this view.

The RCN has a number of different Leadership Programmes including the Primary Health Care Leadership Programme, the Clinical Leadership Programme and the Political Leadership Programme. The RCN would welcome a strategic approach to examining the different types of leadership programmes to ensure the best development of skills in leadership at all levels of the health service. This should be based on a framework which reflects the values and purpose of the health service. The RCN would also suggest that leadership programmes are evaluated in terms of their impact on patient care and against stated programme outcomes. The RCN intends to work closely with the Leadership Centre in this development.

The systems for assuring competence

69 Regulation of health care professionals is not just about disciplinary matters. It should be understood as encapsulating all of the systems which combine to assure the competence of

health care professionals: education, registration, training, CPD and revalidation as well as disciplinary matters.

70 *For each group of health care professionals (doctors, nurses and midwives, the professions allied to medicine, and managers) there should be one body charged with overseeing all aspects relating to the regulation of professional life: education, registration, training, CPD, revalidation and discipline. The bodies should be: for doctors, the GMC; for nurses and midwives, the new Nursing and Midwifery Council; for the professions allied to medicine, the re-formed professional body for those professions; and for senior health care managers, a new professional body.*

71 *In addition, a single body should be charged with the overall co-ordination of the various professional bodies and with integrating the various systems of regulation. It should be called the Council for the Regulation of Health care Professionals. (In effect, this is the body currently proposed in 'The NHS Plan', and referred to as the Council of Health care Regulators.)*

72 *The Council for the Regulation of Health care Professionals should be established as a matter of priority. It should have a statutory basis. It should report to Parliament. It should have a broadly-based membership, consisting of representatives of the bodies which regulate the various groups of health care professionals, of the NHS, and of the general public.*

73 *The Council for the Regulation of Health Care Professionals should have formal powers to require bodies which regulate the separate groups of health care professionals to conform to principles of good regulation. It should act as a source of guidance and of good practice. It should seek to ensure that in practice the bodies which regulate health care professionals behave in a consistent and broadly similar manner.*

74 *It should be a priority for the Council for the Regulation of Health care Professionals to promote common curricula and shared learning across the professions.*

The RCN welcomes the Government commitment to establish a Council for the Regulation of Health Care Professionals.

The RCN welcomes the recommendation that an over-arching body be set up to co-ordinate and integrate the work of the individual professional regulatory bodies. This Council will allow a broader focus on the interests and protection of the public. Its over-arching nature will promote an independent approach and should permit a purer focus on principles.

If the interests of the public are paramount to each professional group, there should be less need for differences in approach between the professions. There are already examples of good practice within the work of the individual regulatory bodies. The RCN would welcome sharing examples of best practice. This will reduce tribal boundaries in the interest of improving health care.

Every effort should be made to ensure that this new Council does not increase bureaucracy. It should have terms of reference that are distinctly different from those of the individual professional regulatory bodies.

It should be noted that there is the unresolved issue of the regulation of health care assistants. Clearly this is a group of personnel who offer health care to the public, who currently are not subject to regulation of any kind.

The proposed focus on shared learning across common curricula is most welcome. There are examples of good practice in this area, but they are by no means widely accepted. It requires an overarching body to have the authority and the drive to bring this about. Academics from each of the health care professions should come together to look afresh at common themes that could be taught together. If the curriculum for each profession were to focus on the patient, themes should emerge that result in a change in emphasis in many of the subjects studied. For example, communication skills would be as important as physiology.

The education of health care professionals

75 *Pilot schemes should be established to develop and evaluate the feasibility of making the first year's course of undergraduate education common to all those wishing to become health care professionals.*

76 *Universities should develop closer links between medical schools and schools of nursing education with a view to providing more joint education between medical and nursing students.*

77 *Universities should develop closer links between medical and nursing schools and centres for education and training in health service and public sector management, with a view to enabling all health care professionals to learn about management.*

78 *Access to medical schools should be widened to include people from diverse academic and socio-economic backgrounds. Those with qualifications in other areas of health care and those with an educational background in subjects other than science, who have the ability and wish to do so, should have greater opportunities than is presently the case, to enter medical schools.*

79 *The attributes of a good doctor, as set down in the GMC's 'Good Medical Practice', must inform every aspect of the selection criteria and curricula of medical schools.*

80 *The NHS and the public should be involved in (a) establishing the criteria for selection and (b) the selection of those to be educated as doctors, nurses and as other health care professionals.*

The RCN supports the recommendation for closer links between medical and nursing schools and centres for education and training in health service and public sector management. Whilst the UKCC competencies encompass the management of care, the RCN believes that there are also opportunities to share the principles of management with other health care professions.

The RCN supports the recommendation to widen access to medical schools. A great deal of work has been undertaken within the nursing profession on widening the entrygate to pre-registration education, in order to ensure that the applicants' current level of knowledge is recognised and accredited. In widening access to medical schools, there is a need for a careers service which:

- removes the 'traditional' view of medicine as being purely scientifically focussed
- recognises prior learning and experience both in practice and academically

- actively encourages mature students and students from different economic and cultural backgrounds

Post-qualification training and continuing professional development

81 *In relation to doctors, we endorse the proposal to establish a Medical Education Standards Board (MESB), to co-ordinate postgraduate medical training. The MESB should be part of and answerable to the GMC which should have a wider role.*

82 *CPD, being fundamental to the quality of care provided to patients, should be compulsory for all health care professionals.*

83 *Trusts and primary care trusts should provide incentives to encourage health care professionals to maintain and develop their skills. The contract (or, in the case of GPs, other relevant mechanism) between the trust and the health care professional should provide for the funding of CPD and should stipulate the time which the trust will make available for CPD.*

84 *Trusts and primary care trusts must take overall responsibility through an agreed plan for their employees' use of the time allocated to CPD. They must seek to ensure that the resources deployed for CPD contribute towards meeting the needs of the trust and of its patients, as well as meeting the professional aspirations of individual health care professionals.*

The RCN believes that it will only be possible to develop a modern effective health care system with employers being fully committed to their organisations within a culture of clinical governance.

The RCN supports the proposal to establish a Medical Education Standards Board (MESB) to co-ordinate postgraduate medical training. The development of education standards should lead to an equitable provision of postgraduate training.

The RCN supports the recommendation that continuing professional development should be compulsory for all health care professionals. Health care professions need to develop robust systems for monitoring CPD activity. The RCN supports structures and processes to ensure compliance with the CPD standard. A broad view needs to be taken as to what constitutes as CPD activity, where the outcomes can be related to professional practice.

The RCN supports the spirit behind the recommendation that trusts and primary care trusts should provide incentives to encourage health care professionals to maintain and develop their skills. The health service should ensure that staff have provision for funding CPD. The RCN also suggests that each trust should establish an appropriate structure to manage a staff development fund. The management of this fund should be based on principles to include the following:

- Equal opportunity
- Funded activity should be used to further best practice
- Funded CPD should be available for the individual health care professional.

Feedback from the RCN clinical governance focus groups highlights continuing problems for nurses to find the time, support, and resources to

undertake CPD. There are RCN initiatives to make e-based learning opportunities more readily available.

Patients and the public should be involved in establishing the criteria for selection and in the selection of health care professionals. The public's contribution to this process should be explicitly defined to minimise the possibility of failure because of a poorly defined remit. Furthermore, to achieve successful involvement, appropriate training and support would need to be provided for both the public and health care professionals involved in this process.

Appraisal

85 *Periodic appraisal should be compulsory for all health care professionals. The requirement to participate in appraisal should be included in the contract of employment.*

86 *The commitment in 'The NHS Plan' to introduce regular appraisal for hospital consultants must be implemented as soon as possible.*

87 *The requirement to undergo periodic appraisal should also be incorporated into GPs' terms of service.*

The RCN supports the recommendation that periodic appraisal should be compulsory for all health care professionals, and recommends that annual performance appraisal should be included in employment contracts. The review of annual performance should be based on key principles, which include:

- Objective setting
- Action-oriented
- Personal development

The objectives for the review period should be specific, measurable, achievable, realistic and relevant, and time-bound. They should reflect the needs of the organisation in terms of best practice and continuous quality improvement. Line managers have a responsibility in supporting individuals in achieving their objectives, and periodic review is recommended mid-way during the cycle. Different models of support and supervision can also facilitate this process such as the use of action learning sets, coaching and clinical supervision. All trusts should consider applying for 'Investors in People', as the process would ensure a strong focus on performance review.

Revalidation

88 *Periodic revalidation, whereby health care professionals demonstrate that they remain fit to practise in their chosen profession, should be compulsory for all health care professionals. The requirement to participate in periodic revalidation should be included in the contract of employment.*

89 *The public, as well as the employer and the relevant professional group, must be involved in the processes of revalidation.*

90 *The new Council for the Regulation of Health care Professionals should take as a further priority an early review of the various systems of revalidation and re-registration to ensure that they are sufficiently rigorous, and in alignment both with each other and with other initiatives*

to protect the public. The Council should also seek ways to incorporate managers (as health care professionals) into the systems of CPD, appraisal and revalidation.

The RCN supports the recommendation that periodic revalidation should be compulsory for health care professionals, and that this requirement is included in employment contracts. Each of the professions needs to agree the period between each revalidation. A period not exceeding three years is recommended. Revalidation should be based on a minimum of two standards: a practice standard and a CPD standard. The practice standard should specify the minimum hours of work required in the validation period as well as the legitimacy of the work activity.

The RCN supports the involvement of the public, the employer, and the relevant profession in the process of revalidation. Further consideration needs to be given as to how the public will be involved in the process. Sending out the proposed model for revalidation to key stakeholders for consultation is one way of addressing this recommendation.

The new Council for the Regulation of Health care professionals should review the systems in operation and facilitate the sharing of best practice. The Council might consider developing a 'code of best practice' based on a number of precepts for revalidation (similar to the QAA codes). Each regulatory body could then review their profession-specific revalidation procedures with reference to the code.

Managers

91 Managers as health care professionals should be subject to the same obligations as other health care professionals, including being subject to a regulatory body and professional code of practice. (See Recommendation 70.)

The RCN is in agreement with this recommendation. The RCN would expect to be included in the development of such a body as many health care managers are nurses.

Clinicians who hold managerial positions

92 Where clinicians hold managerial roles which extend beyond their immediate clinical practice, sufficient protected time in the form of allocated sessions must be made available for them to carry out that managerial role.

93 Any clinician, before appointment to a managerial role, must demonstrate the managerial competence to undertake what is required in that role: training and support should be made available by trusts and primary care trusts.

94 Clinicians should not be required or expected to hold managerial roles on bases other than competence for the job. For example, seniority or being next in turn are not appropriate criteria for the appointment of clinicians to managerial roles.

95 The professional and financial incentives for senior clinicians to undertake full-time senior managerial roles should be reviewed: the aim should be to enable senior clinicians to move into a full-time managerial role, and subsequently, if they so wish, to move back into clinical practice after appropriate retraining and revalidation.

96 *To protect patients, in the case of clinicians who take on managerial roles but wish to continue to practise as clinicians, experts together with managers from the NHS should issue advice as to the minimum level of regular clinical practice necessary to enable a clinician to provide care of a good quality. Clinicians not maintaining this level of practice should not be entitled to offer clinical care. This rule should also apply to all other clinicians who, for whatever reason, are not in full-time practice, and not only to those in part-time managerial roles.*

97 *To facilitate the movement of clinicians in and out of managerial positions, the proposed systems for the revalidation (and re-registration) of doctors, nurses and professions allied to medicine should distinguish between professionals who are managers and also maintaining a clinical practice and those who are not. Those who are not maintaining a clinical practice should be entitled to obtain the appropriate revalidation (and re-registration) to restart a clinical practice, after retraining, and should be assisted in doing so. (See Recommendation 95.)*

98 *The relevant professional regulatory bodies should make rules varying the professional duties of those professionals, whose registration they hold, who are in full-time managerial roles, so as to take account of the fact that, while occupying such roles, they do not undertake responsibility for the care of patients.*

The RCN agrees that competent managers are a vital part of the health service structure. Any clinician taking on a management role must be given sufficient time to carry out the managerial function and clinical responsibilities will therefore need to be reduced.

The existing culture accepts that any clinician can step into a management role, provided that they have credibility amongst their peers. This undermines the recognition of the professional skills that are required to be an effective manager. Management skills should be identified by the new Management Body, together with education and training facilities and assessment strategies. The RCN agrees that excellent clinicians do not necessarily make the best managers and supports the view that 'taking a turn' is not the way to make a selection.

Senior clinicians of all disciplines should be enabled to move in and out of managerial roles and there should be appropriate re-education and clinical assessment.

The RCN believes that clinicians who are not in full-time practice should be assessed to see that their practice is of an acceptable quality. However, the total loss of an experienced clinician from the work-force can impact, not only on the workload, but also on the supervision of colleagues. Wherever possible agreement should be reached so that time is made available for management functions. The length of time for which the clinician is to carry out this role would also have some significance for the decision regarding the appropriate model chosen.

A similar situation arises with the position of teacher/practitioners. The RCN maintains that the teacher is more effective if he or she continues to keep close clinical contact.

The relevant professional regulatory bodies should vary their rules so as to enable those working in a management capacity to remain on the appropriate professional register.

The acquisition and development of new clinical skills

99 *Any clinician carrying out any clinical procedure for the first time must be directly supervised by colleagues who have the necessary skill, competence and experience until such time as the relevant degree of expertise has been acquired.*

100 *Before any new and hitherto untried invasive clinical procedure can be undertaken for the first time, the clinician involved should have to satisfy the relevant local research ethics committee that the procedure is justified and it is in the patient's interests to proceed. Each trust should have in place a system for ensuring that this process is complied with.*

101 *Local research ethics committees should be re-formed as necessary so that they are capable of considering applications to undertake new and hitherto untried invasive clinical procedures.*

102 *Patients are always entitled to know the extent to which a procedure which they are about to undergo is innovative or experimental. They are also entitled to be informed about the experience of the clinician who is to carry out the procedure.*

103 *The Royal College of Surgeons of England should, in partnership with university medical schools and the NHS, be enabled to develop its unit for the training of surgeons, particularly in new techniques. It should also explore the question of whether there is an age beyond which surgeons, specifically in areas such as paediatric cardiac surgery, should not attempt new procedures or even should not continue in a particular field of surgery.*

The RCN agrees that any clinicians carrying out clinical procedures for the first time must be directly supervised by colleagues. Supervision must be maintained until the relevant degree of expertise has been acquired. This is the bedrock of clinical development. The RCN also believes that robust mentorship systems should be in place for all health care professionals undertaking education programmes involving practice. The student would have a named person able to provide support and who is skilled in the necessary procedures. The mentor would have an understanding of the student's capabilities and knowledge.

The RCN suggests that membership of local research ethics committees be reviewed to ensure that they reflect the multi-professional and patient-centred approach advocated of the health service.

The RCN supports the principles underpinning the training of surgeons in new techniques and imposing age limits in specialist practice areas. The RCN believes this affords a real opportunity to incorporate these issues into appraisal and revalidation.

Much nursing practice is not evidence based and never will be. Nurses have to know what recognised best practice is.

Discipline

104 *In the exercise of their disciplinary function the professional regulatory bodies must adopt a more flexible approach towards what constitutes misconduct. They must deal with cases, as far as possible, at a local level and must have available a range of actions which both serve the interests of the public and the needs of the professional.*

105 *The need to involve the public in the various professional regulatory bodies applies as much to discipline as to all the other activities of these bodies (see Recommendation 42).*

The RCN supports the recommendation that professional bodies should exercise a more flexible approach towards what constitutes misconduct. Each profession needs to establish which activities can be dealt with locally under the extant policy on discipline. For example, in nursing, some drug administration errors are managed by the employers with an emphasis on retraining to prevent recurrence.

Section 4: The safety of care

106 *We support and endorse the broad framework of recommendations advocated in the report 'An Organisation with a Memory' by the Chief Medical Officer's expert group on learning from adverse events in the NHS. The National Patient Safety Agency proposed as a consequence of that report should, like all other such bodies which contribute to the regulation of the safety and quality of health care, be independent of the NHS and the DoH.*

107 *Every effort should be made to create in the NHS an open and non-punitive environment in which it is safe to report and admit sentinel events.*

108 *Major studies should, as a matter of priority, be carried out to investigate the extent and type of sentinel events in the NHS to establish a baseline against which improvements can be made and measured.*

Feedback from clinical governance groups highlights the importance of an open, non-punitive environment. This is not an environment that most nurses work in. This shows the extent to which the culture in the health service needs changing.

A national reporting system

109 *There should be a single, unified, accessible system for reporting and analysing sentinel events, with clear protocols indicating the categories of information which must be reported to a national database.*

110 *The national database of sentinel events should be managed by the National Patient Safety Agency, so as to ensure that a high degree of confidence is placed in the system by the public.*

111 *The National Patient Safety Agency, in the exercise of its function of surveillance of sentinel events, should be required to inform all trusts of the need for immediate action, in the light of occurrences reported to it. The Agency should also be required to publish regular reports on patterns of sentinel events and proposed remedial actions.*

112 *All sentinel events should be subject to a form of structured analysis in the trust where they occur, which takes into account not only the conduct of individuals, but also the wider contributing factors within the organisation which may have given rise to the event.*

The RCN welcomes the recommendation that the structured analysis of a sentinel event takes into account the wider contributing factors. Developing effective reporting systems is highly complex and takes significant time and support to develop. It is dependent on developing local data capture systems that are practical and which clinical staff own. Reporting incidents has to be made as easy as possible. It is important that clinical staff receive feedback on how incidents are followed up and what the organisation is learning from the reporting processes. Incident reporting should not be seen as a paper exercise that someone else (often a manager) does. The RCN's clinical governance focus groups have highlighted the considerable cultural barriers that currently exist and which mitigate against open, non-punitive reporting systems. However, these groups have also identified examples of good practice, such as that developed at Glenfield Hospital in Leicester (summarised in the RCN clinical governance publication - 'Clinical Governance: How nurses can get involved'). A range of new systems were introduced, following a series of adverse incidents relating to the

administration of intravenous heparin, for example, re-designing prescription sheets, providing staff education and the development of a 'no blame' statement by the trust board.

Another good example is the breakthrough collaborative series run by the Institute of Health care Improvement in the USA on reducing medical error and improving patient safety. This is the same model that the Cancer Services Collaborative and the Primary Care Collaborative are using to facilitate rapid cycle improvement and shared organisational learning in the NHS.

Incentives to encourage the reporting of sentinel events

113 *The reporting of sentinel events must be made as easy as possible, using all available means of communication (including a confidential telephone reporting line).*

114 *Members of staff in the NHS should receive immunity from disciplinary action by the employer or by a professional body if they report a sentinel event to the trust or to the national database within 48 hours, except where they themselves have committed a criminal offence.*

15 *Members of staff in the NHS who cover up or do not report a sentinel event may be subject to disciplinary action by their employer or by their professional body.*

116 *The opportunity should exist to report a sentinel event in confidence.*

117 *There should be a stipulation in every health care professional's contract that sentinel events must be reported, that reporting can be confidential, and that reporting within a specified time period will not attract disciplinary action.*

118 *The process of reporting of sentinel events should be integrated into every trust's internal communications, induction training and other staff training. Staff must know what is expected of them, to whom to report and what systems are in place to enable them to report.*

The RCN does not agree with the recommendation that staff in the NHS should receive immunity from disciplinary action by the employer or the regulatory body. However the RCN does approve of the recommendation that reporting can be made in confidence and that this should be a mandatory part of the contract of employment. At a general level, linking reporting of sentinel events to disciplinary action seems to run counter to the development of the non punitive culture. There is a current focus on a blame culture. The concept of reporting linked to disciplinary action is linked with a negative approach. The RCN knows how hard it is for nurses to whistleblow. This could be heightened by notions of immunity from disciplinary action.

Staff should have the opportunity to report, in confidence, to an independent body, incidents in which they have been involved, on the understanding that that information is privileged. This would also encourage staff to give an 'opinion' of how or why the incident occurred, and perhaps could have been avoided. None of this would prevent the patient (police or other investigatory body) from investigating the circumstances of an incident, including obtaining relevant medical/nursing records, and interviewing witnesses. The process to which privilege applies should be additional to the existing avenues of enquiry.

There needs to be a greater understanding of the difference between incompetent staff and conscientious and competent staff who occasionally make errors which are not culpable. Disciplining every member of staff who makes a drug error is unlikely to have any deterrent value, and will not lead to a reduction in drug errors, either by that practitioner or any one else. These errors usually arise from systems failings.

The system of clinical negligence

119 In order to remove the disincentive to open reporting and the discussion of sentinel events represented by the clinical negligence system, this system should be abolished. It should be replaced by an alternative system for compensating those patients who suffer harm arising out of treatment from the NHS. An expert group should be established to advise on the appropriate method of compensation to be adopted.

The RCN is part of the Chief Medical Officer Working Group to review clinical negligence in England. The RCN believes that the expert group should consider extending the remit of this work to employee accidents at work.

Designing for safety

120 The proposed National Patient Safety Agency should, as a matter of urgency, bring together managers in the NHS, representatives of the pharmaceutical companies and manufacturers of medical equipment, members of the health care professions and the public, to seek to apply approaches based on engineering and design so as to reduce (and eliminate to the extent possible) the incidence of sentinel events.

The RCN welcomes this recommendation and looks forward to being involved in the work of the National Patient Safety Agency.

Incorporating a concern for safety into systems and policies

121 At the level of individual trusts, an executive member of the board should have the responsibility for putting into operation the trust's strategy and policy on safety in clinical care. Further, a non-executive director should be given specific responsibility for providing leadership to the strategy and policy aimed at securing safety in clinical care.

The RCN agrees and suggests that the Department of Health guidance on whistleblowing is reviewed. This requires that a non executive director takes responsibility for whistleblowing. The RCN has found that this does not happen in many trusts.

Section 5 Care of an appropriate standard

122 *One body should be responsible for co-ordinating all action relating to the setting, issuing and keeping under review of national clinical standards: this should be NICE, suitably structured so as to give it the necessary independence and authority.*

123 *Once the recommended system is in place, only NICE should be permitted to issue national clinical standards to the NHS. The DoH (as the headquarters of the NHS) while issuing, for example, National Service Frameworks and supplementary guidance, should not be able to rescind or detract from the standards issued by NICE.*

124 *NICE should pursue vigorously its current policy of involving as wide a community as possible, including the public, patients and carers, in the work to develop and keep under review clinical standards. In particular, the special expertise of the Royal Colleges and specialist professional associations should be harnessed and supported. Account should also be taken of the expertise of the senior management of the NHS.*

125 *National standards of clinical care should reflect the commitment to patient-centred care and thus in future be formulated from the perspective of the patient. The standards should address the quality of care that a patient with a given illness or condition is entitled to expect to receive from the NHS. The standards should take account of the best available evidence. The standards should include guidance on how promptly patients should get access to care. They should address the roles and responsibilities of the various health care professionals who will care for the patient. They should take account of the patient's journey from primary care, into the hospital system (if necessary), and back to primary and community care, and of the necessary facilities and equipment.*

126 *Such standards for clinical care as are established should distinguish clearly between those which are obligatory and must be observed, and those to which the NHS should aspire over time.*

127 *A timetable over the short, medium and long term should be published, and revised periodically, for the development of national clinical standards, so that the public may be consulted and kept aware of those areas of health care which are covered by such standards and those which will be covered in the future. Target dates should be set by which clinical standards will have been prepared for all major conditions and illnesses.*

128 *Resources, and any necessary statutory authority, must be made available to NICE to allow it to perform its role of developing, issuing and keeping under review national clinical standards.*

129 *Standards of clinical care which patients are entitled to expect to receive in the NHS should be made public.*

When multiple guidelines exist on the same topic, it is potentially confusing and difficult to make decisions about what constitutes a 'good' guideline. However, the RCN would question the capacity of a single organisation such as NICE to develop all the guidelines that are needed by the NHS. Some clinical questions that may be highlight significant to patients may never be considered overall NHS priorities.

A more workable solution may be to find ways in which the professional organisations could work more closely with NICE to ensure consistent methods are use to develop national guidelines. NICE could also take on the role of endorsing or accrediting standards developed by professional organisations. The public and health care professionals would then be able to

recognise those guidelines which have been approved at a national level, even though they may not have been developed directly by NICE.

The RCN would also encourage the development of closer relationships between NICE and SIGN, in terms of sharing priority lists and work plans. The current situation means the same guidelines are being produced in Scotland (SIGN) and England and Wales (NICE). This is an unnecessary duplication of limited resources.

The RCN also highlights the importance of paying attention to processes of dissemination and implementation. Guidelines are no use unless they reach the point of delivering care to the patient. Many health care professionals are not aware of the existence of guidelines, even those produced by NICE. Nurses cannot assume that producing high quality guidelines will improve practice and the existing research evidence shows that this is not the case. There is a need to develop more effective dissemination and implementation strategies. This is an area where professional organisations have a key role to play.

RCN forums will be able to influence the work of the national standards. Clinicians will be the leaders in this work and the RCN can offer its expert members to make their contribution.

The RCN endorses the need to formulate national standards of clinical care on the basis of patient's perspective. In stating that these standards should take into account the best available evidence, it is vital to remember that the patients experience is also a form of evidence.

Standards of care: NHS organisations

130 There must be a single, coherent, co-ordinated set of generic standards: that is, standards relating to the patient's experience and the systems for ensuring that care is safe and of good quality (for example corporate management, clinical governance, risk management, clinical audit, the management and support of staff, and the management of resources). Trusts must comply with these standards.

131 The current system of inspection of trusts and primary care trusts should be changed to become a system of validation and periodic revalidation of these trusts. The system should be supportive and flexible. Its aim should be to promote continued improvement in the quality of care.

132 One body should be responsible for validating and re-validating NHS trusts and primary care trusts. This body should be CHI, suitably structured so as to give it the necessary independence and authority. Other bodies (for example the NHS Litigation Authority) which are currently concerned with setting and requiring compliance with those generic standards which should fall within the authority of CHI, should carry out their role in this respect under the authority of and answerable to CHI.

133 Validation and revalidation of trusts should be based upon compliance with the generic standards which relate to the patient's experience and the systems for ensuring that care is safe and of good quality.

134 The standards against which trusts are to be validated, and the results of the process of validation or revalidation, should be made public. We choose the term 'validation' not only to

mirror the process which health care professionals will have to undergo, but also to indicate that, while akin to licensing it contemplates more. Licensing tends to be thought of as a 'one-off event', whereas to us validation is a process.

135 *Any organisation in the voluntary or private sector which provides services to NHS patients should be required to meet the standards for systems, facilities and staff which organisations in the NHS must meet. The aim should be that, wherever care is funded by the NHS, there is a single system of validation which indicates to the public that the organisation meets the necessary standards.*

136 *The validating body should have the power to withdraw, withhold or suspend a trust's validation if standards fall such as to threaten the quality of care or the safety of patients. Any trust or organisation whose validation may be affected in this way must be given the opportunity to take appropriate remedial action. It must then satisfy CHI that it has taken remedial action before its continued validation can be confirmed.*

137 *CHI should consider how it might work with the providers of those programmes of accreditation already adopted by a significant number of trusts. In the future, where required standards are met, CHI should accept as part of its validation process the accreditation obtained through these programmes.*

138 *The process of validation of trusts should, in time, be extended to cover discrete, identifiable services within trusts. This extension of validation should first be piloted and evaluated.*

139 *The pilot exercise for this form of validation should include children's acute hospital services and paediatric cardiac surgery.*

140 *Should the pilot exercise be successful, the category of discrete services which should be a priority for this form of validation are those specialist services which are currently funded or meet the criteria for funding by the National Specialist Commissioning Group (the successor to the Supra Regional Services Advisory Group).*

141 *For discrete services, whether specialist services or otherwise, to be validated trusts they must be able to demonstrate that all relevant aspects of the service can currently be met, rather than that the trust aims to develop so as to be able to do so at some point in the future. Trusts which do not meet the necessary standards to ensure the safety of patients and a good quality of care should not be permitted to offer, or continue to offer, the relevant service.*

142 *Where the interests of securing quality of care and the safety of patients require that there be only a small number of centres offering a specialist service, the requirements of quality and safety should prevail over considerations of ease of access. It is and should be the responsibility of the NHS to assist patients, and their families or carers, with the cost of transport and accommodation when they have to travel away from home to receive specialist services. Such support should not be the subject of a means test.*

Monitoring standards and performance

Local monitoring

143 *The process of clinical audit, which is now widely practised within trusts, should be at the core of a system of local monitoring of performance. Clinical audit should be multidisciplinary.*

144 *Clinical audit must be fully supported by trusts. They should ensure that health care professionals have access to the necessary time, facilities, advice and expertise in order to conduct audit effectively. All trusts should have a central clinical audit office which co-ordinates audit activity, provides advice and support for the audit process, and brings together the results of audit for the trust as a whole.*

145 *Clinical audit should be compulsory for all health care professionals providing clinical care and the requirement to participate in it should be included as part of the contract of employment.*

The RCN would agree that local clinical audit is important. In many settings it is not happening at present. The RCN's clinical governance focus groups report that many clinical nurses are not participating in audit. Reported problems include lack of time, resource or skills or because of organisational hierarchies and lack of team work. The proposals that these issues should be addressed as core non-clinical skills in undergraduate/pre-registration preparation are welcome. There is a need to find ways to improve staff involvement in audit at a clinical level. This has to make sure that staff receive feedback about how audit results feed into organisational decision making. This has to be seen as more than a paper exercise. The RCN has highlighted the importance of audit approaches that are patient-focused, practitioner led and which build a sense of involvement and ownership amongst staff and patients alike. These principles have underpinned the RCN's national sentinel audit of venous leg ulcer care. A process of facilitating clinical staff to collect and analyse audit data and implement changes in practice, demonstrated significant improvements in the clinical and cost effectiveness of leg ulcer care between the first and second rounds of audit data collection.

The RCN would question whether audit should be a part of the contract of employment. It may be appropriate for this to be incorporated into an individual's personal objectives and regular performance appraisal.

National monitoring

146 *The monitoring of clinical performance at a national level should be brought together and co-ordinated in one body: an independent Office for Information on Health care Performance. This Office should be part of CHI.*

147 *The Office for Information on Health care Performance should supplant the current fragmentation of approach through a programme of activities involving the co-ordination of the various national audits. In addition to its other responsibilities, the new system should provide a mechanism for surveillance whereby patterns of performance in the NHS which may warrant further scrutiny can be identified as early as possible.*

The RCN welcomes the Government's commitment to introduce the Office for Information on Health care Performance, announced the same day that the Report was published.

To ensure that audit tools themselves are evidence based, they should be developed in conjunction with national clinical guidelines. The RCN believes that it would make more sense, therefore, for audit tool development to remain within the remit of NICE, even if the conduct of national audits comes within the remit of CHI.

Developing audit tools alongside guidelines is the approach taken by the RCN in relation to the management of leg ulcers, the recognition and assessment of acute pain in children and pressure ulcer risk assessment and prevention. This promotes a more continuous approach that links evidence,

implementation, audit and quality improvement. This is crucially important given the recognised problems of implementing evidence into practice.

Information systems

148 *The current 'dual' system of collecting data in the NHS in separate administrative and multiple clinical systems is wasteful and anachronistic. A single approach to collecting data should be adopted, which clinicians can trust and use and from which information about both clinical and administrative performance can be derived.*

149 *Steps should be taken nationally and locally to build the confidence of clinicians in the data recorded in the Patient Administration Systems in trusts (which is subsequently aggregated nationally to form the Hospital Episode Statistics). Such steps should include the establishment by trusts of closer working arrangements between clinicians and clinical coding staff.*

150 *The Hospital Episode Statistics database should be supported as a major national resource which can be used reliably, with care, to undertake the monitoring of a range of health care outcomes..456*

151 *Systems for clinical audit and for monitoring performance rely on accurate and complete data. Competent staff, trained in clinical coding, and supported in their work are required: the status, training and professional qualifications of clinical coding staff should be improved.*

152 *The system of incentives and penalties to encourage trusts to provide complete and validated data of a high quality to the national database should be reviewed. Any new system must include reports of each trust's performance in terms of the quality and timeliness of the submission of data. The systems within a trust for producing data of a high quality, and its performance in returning such data in a timely manner to the national database, should be taken into account in the process of validating and revalidating the trust.*

153 *At national level, the indicators of performance should be comprehensible to the public as well as to health care professionals. They should be fewer and of high quality, rather than numerous but of questionable or variable quality.*

154 *The need to invest in world-class IT systems must be recognised so that the fundamental principles of data collection, validation and management can be observed: that data be collected only once; that the data be part and parcel of systems used to support health care professionals in their care of patients; and that trusts and teams of health care professionals receive feedback when data on their services are aggregated.*

Access to IT systems and the supporting IT skills is a major problem reported by clinical nursing staff, particularly those in the community. IT skills should be one of the core non-clinical skills that are included in educational programmes for health care workers. The RCN is involved in an Information Strategy to improve information literacy and make information more accessible to nurses.

Publication of information about performance and standards

155 *Patients and the public must be able to obtain information as to the relative performance of the trust and the services and consultant units within the trust.*

156 *As part of their Annual Reports trust boards should be required to report on the extent of their compliance with the national clinical standards. These reports should be made public and be made available to CHI.*

While it is important that the public has access to information about the relative performance of trusts and the services and consultant units, it is important that this information is understandable and meaningful to patient's and the public and not only to health care professionals.

Section 6: Public involvement through empowerment

157 *The involvement of the public in the NHS must be embedded in its structures: the perspectives of patients and of the public must be heard and taken into account wherever decisions affecting the provision of health care are made.*

158 *Organisations which are not part of the NHS but have an impact on it, such as Royal Colleges, the GMC, the Nursing and Midwifery Council and the body responsible for regulating the professions allied to medicine, must involve the public in their decision-making processes, as they affect the provision of health care by the NHS.*

159 *The processes for involving patients and the public in organisations in the NHS must be transparent and open to scrutiny: the annual report of every organisation in the NHS should include a section setting out how the public has been involved, and the effect of that involvement.*

160 *The public's involvement in the NHS should particularly be focused on the development and planning of health care services and on the operation and delivery of health care services, including the regulation of safety and quality, the competence of health care professionals, and the protection of vulnerable groups.*

161 *Proposals to establish Patients' Forums and Patients' Councils must allow for the involvement of the wider public and not be limited only to patients or to patients' groups. They must be seen as an addition to the process of involving patients and the public in the activities of the NHS, rather than as a substitute for it.*

162 *The mechanisms for the involvement of the public in the NHS should be routinely evaluated. These mechanisms should draw on the evidence of what works.*

163 *The process of public involvement must be properly supported, through for example, the provision of training and guidance.*

164 *Financial resources must be made available to enable members of the public to become involved in NHS organisations: this should include provision for payments to cover, for example, the costs of childcare, or loss of earnings.*

165 *The involvement of the public, particularly of patients, should not be limited to the representatives of patients' groups, or to those representing the interests of patients with a particular illness or condition: the NHS Modernisation Agency should advise the NHS on how to achieve the widest possible involvement of patients and the public in the NHS at local level.*

166 *Primary care trusts (and groups), given their capacity to influence the quality of care in hospitals, must involve patients and the public, for example through each PCG/T's Patient and Advocacy Liaison Service. They must make efforts systematically to gather views and feedback from patients. They must pay particular attention to involving their local community in decision-making about the commissioning of hospital services.*

Involvement of the public must be embedded in the structures of the health service. This involvement must be publicly documented to demonstrate its importance, its impact and to encourage future patient and public involvement.

The RCN agrees there is a need for organisations that are not part of the health service to involve the public in their decision-making processes. The RCN has already started this process and is currently developing a strategy to involve patients and the public at all levels of the organisation. We have held

meetings in the four countries with relevant individuals, including patients and patient groups to discuss the most appropriate strategy for the organisation.

The RCN would emphasise the need for the impact of patient and public involvement to be clearly and explicitly stated, as this has been an area of weakness in the past.

The recommendations are that public involvement should be particularly focused on the development and planning of health care services, the operation and delivery of health care services, (including the regulation of safety and quality), the competence of health care professionals and the protection of vulnerable groups. It is vital to recognise that these areas represents a complex and varied set of opportunities for involvement. This should be reflected in a range of approaches to and methodologies sensitive to the range of approaches to involvement, rather than a few blanket approaches. These methodologies should also be collated and provided as a central source of information, to aid future initiatives.

The RCN endorses the need to evaluate the mechanisms of patient and public involvement. Patients and the public should also be involved in developing the criteria that will be used to judge the success of involvement. It is vital that public involvement is supported through a process of support and training and guidance. Without this, its impact is likely to be minimal. The availability of financial resources is a key element in achieving successful involvement. The ring fencing of specific funds will acknowledge the importance of public involvement, which has often been poorly resourced by past initiatives.

Section 7: The care of children

Responsibility for children's services

167 A National Director for Children's Health care Services should be appointed to promote improvements in health care services provided for children.

168 Consideration should be given to the creation of an office of Children's Commissioner in England, with the role of promoting the rights of children in all areas of public policy and seeking improvements to the ways in which the needs of children are met. Health care would be one of the areas covered by such a commissioner. Were such an office to be created, we would see it as being in addition to, rather than in place of, our other recommendations about the need to improve the quality of leadership in children's health care services.

169 The Cabinet Committee on Children and Young People's Services should specifically include in its remit matters to do with health care and health services for children and young people.

170 Each health authority and each primary care group or primary care trust should designate a senior member of staff who should have responsibility for commissioning children's health care services locally.

171 All trusts which provide services for children as well as adults, should have a designated executive member of the board whose responsibility it is to ensure that the interests of children are protected and that they are cared for in a paediatric environment by paediatrically trained staff.

The RCN welcomes all these recommendations. The RCN is delighted to welcome the appointment of Professor Al Aynsley Green as the National Director for Children's Services.

The RCN maintains that a Children's Commissioner for England is needed to complement the role of the Children's Commissioner for Wales.

Setting standards for children's health care services

172 The proposed National Service Framework (NSF) for children's health care services must be agreed and implemented as a matter of urgency.

173 The NSF should include a programme for the establishment of standards in all areas of children's acute hospital and health care services.

174 The NSF should set obligatory standards which must be observed, as well as standards to which children's services should aspire over time.

175 The NSF should include incentives for the improvement of children's health care services, with particular help being given to those trusts most in need.

176 The NSF must include plans for the regular publication of information about the quality and performance of children's health care services at national level, at the level of individual trusts, and of individual consultant units.

The RCN is working to ensure that the views of nurses are properly considered in the development of the NSF. This is the only way to ensure that nursing has the central role in future services that the Kennedy Report recommends.

The RCN publications *Standards of Care: Paediatric Nursing 2nd Edition* (1994) which includes a simple audit tool and has been translated into German and Japanese and *Standards of Care Paediatric Nephrology Nursing* (2000) are good examples of RCN commitment to Setting Standards. In addition the RCN has participated in Setting Standards for children and young people with a variety of professional and voluntary organisations. The RCN agrees that some standards will be obligatory and others will be aspirational.

Planning the future of children's health care services

177 *There must be much greater integration of primary, community, acute and specialist health care for children. The NSF should include strategic guidance to health authorities and trusts so that services in the future are better integrated and organised around the needs of children and their families.*

178 *Children's acute hospital services should ideally be located in a children's hospital, which should be physically as close as possible to an acute general hospital. This should be the preferred model for the future.*

179 *In the case of existing free-standing children's hospitals, particular attention must be given to ensuring that, through good management and organisation of care, children have access when needed to (a) facilities which may not routinely be found in a children's hospital and (b) specialists, the appointment of whom in a children's hospital could not be justified given the infrequent call on their services.*

180 *Consideration should be given to piloting the introduction of a system whereby children's hospitals take over the running of the children's acute and community services throughout a geographical area, building on the example of the Philadelphia Children's Hospital in the USA.*

181 *Specialist services for children should be organised so as to provide the best available staff and facilities, thus providing the best possible opportunity for good outcomes. Advice should be sought from experts on the appropriate number of patients to be treated to achieve good outcomes. In planning and organising specialist services, the requirements of quality and safety should prevail over considerations of ease of access.*

182 *Where specialist services for children are concentrated in a small number of trusts spread throughout England, these trusts should establish Family Support Funds to help families to meet the costs arising from travelling and staying away from home. The Funds should be administered flexibly and should not be limited to those on income support or with low incomes.*

183 *After completion of a pilot exercise, all trusts which provide acute hospital services for children should be subject to a process of validation to ensure that they have appropriate child- and family-centred policies, staff, and facilities to provide a good standard of care for children. Trusts which are not so validated should not, save in emergencies, provide acute hospital services for children.*

Honesty, respect and involvement of parents, children and young people are essential to the reconfiguration of services which are necessary to ensure a good quality service is provided. The RCN will continue to support the campaign 'Too dear to visit' by the voluntary organisations Contact a Family and Action for Sick Children for assistance with the cost of travelling and staying away from home to enable parents to be with their sick child.

The RCN believes that validation must involve children, young people and parents as well as staff directly working with them.

The staffing of children's health care services

184 *Children should always (save in exceptional circumstances, such as emergencies) be cared for in a paediatric environment, and always by health care professionals who hold a recognised qualification in caring for children. This is especially so in relation to paediatric intensive care.*

185 *The 1991 standards for the numbers of paediatrically qualified nurses required at any given time should serve as the minimum standard and should apply where children are treated (save in emergencies). The standards should be reviewed as a matter of urgency to take account of changing patterns in the provision of acute health care services..*

186 *All surgeons who operate on children, including those who also operate on adults, must undergo training in the care of children and obtain a recognised professional qualification in the care of children. As matter of priority, the GMC, the body responsible for the revalidation of doctors, should agree with the Royal College of Surgeons of England the appropriate number and range of procedures which surgeons who operate on children must undertake in order to retain their validation. This will have consequences for the way in which general surgery for children is organised.*

The RCN believes that nursing services should be led by senior nurses who have undertaken specific education to acquire the knowledge and skills required to provide good quality health care services for children and young people. Improving career opportunities for children's nurses would assist the retention of experienced nurses. The RCN believes that the number of pre-registration places leading to registration as a registered children's nurse must be reviewed to ensure that minimum staffing standards can be implemented cost –effectively.

The recommendations for reviewing minimum staffing for acute services must include the care of acutely ill children in the community where community children's nursing services must become a universally available service.

Communication between health care professionals, children and their parents or carers

187 *Parents should ordinarily be recognised as experts in the care of their children, and when their children are in need of health care, parents should ordinarily be fully involved in that care.*

188 *Parents of very young children have particular knowledge of their child. This knowledge must be valued and taken into account in the process of caring for the child, unless there is good reason to do otherwise.*

189 *Children's questions about their care must be answered truthfully and clearly.*

190 *Health care professionals intending to care for children should be trained in the particular skills necessary to communicate with parents and with children.*

191 *Health care professionals should be honest and truthful with parents in discussing their child's condition, possible treatment and the possible outcome.*

The RCN believes that the education and staffing levels must acknowledge the time and skills required to communicate effectively with children, young people and their families in an unfamiliar environment at a time of stress. This is encompassed within the RCN's work on the National multi-disciplinary guidelines on the recognition and management of acute pain in children, and the UNICEF UK Child Friendly Health care Initiative.

Section 8: Health care services and treatment for children with congenital heart disease.

192 National standards should be developed, as a matter of priority, for all aspects of the care and treatment of children with congenital heart disease (CHD). The standards should address diagnosis, surgical and other treatments, and continuing care. They should include standards for primary and social care, as well as for hospital care. The standards should also address the needs of those with CHD who grow into adulthood.

193 With regard to paediatric cardiac surgery, the standards should stipulate the minimum number of procedures which must be performed in a hospital over a given period of time in order to have the best opportunity of achieving good outcomes for children. PCS must not be undertaken in hospitals which do not meet the minimum number of procedures. Considerations of ease of access to a hospital should not be taken into account in determining whether PCS should be undertaken at that hospital.

194 With regard to those surgeons who undertake paediatric cardiac surgery, although not stipulating the number of operating sessions sufficient to maintain competence, it may be that four sessions a week should be the minimum number required. Agreement on this should be reached as a matter of urgency after appropriate consultation.

195 With regard to the very particular circumstances of open-heart surgery on very young children (including neo-nates and infants), we stipulate that the following standard should apply unless, within six months of the publication of this Report, this standard is varied by the DoH having taken the advice of relevant experts: there must, in any unit providing open-heart surgery on very young children, be two surgeons trained in paediatric surgery who must each undertake between 40 and 50 open-heart operations a year.

196 The national standards should stipulate that children with CHD who undergo any form of interventional procedure must be cared for in a paediatric environment. This means that all health care professionals who care for these children must be trained and qualified in paediatric care. It also means that children must be cared for in a setting with facilities and equipment designed for children. There must also be access on the same site as where any surgery is performed to a paediatric intensive care unit, supported by trained intensivists.

197 Surgical services for children with very rare congenital heart conditions, such as Truncus Arteriosus, or involving procedures undertaken very rarely, should only be performed in a maximum of two units, validated as such on the advice of experts. Such arrangements should be subject to periodic review.

198 An investigation should be conducted as a matter of urgency to ensure that PCS is not currently being carried out where the low volume of patients or other factors make it unsafe to perform such surgery.

The RCN believes that these recommendations are very welcome.

The RCN agrees with these proposals and further believes that similar recommendations should apply to other aspects of uncommon conditions occurring in childhood requiring highly skilled treatment and care.