

Solihull Hospital
Kennedy
BreastCareReview

Review of the Response of Heart of England NHS Foundation Trust to Concerns about Mr Ian Paterson's Surgical Practice; Lessons to be Learned; and Recommendations

Kennedy Review – Lesson to be learned and recommendations only

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*I should declare that, although I have never previously had any formal contact with the Trust or its constituent Hospitals, my brother Stuart was a surgeon at two of the Hospitals. He ceased to operate after contracting hepatitis from a patient around 1990 and died of liver disease in 1999. It was partly in honour of his memory that I agreed to take on this Review.

14 LESSONS TO BE LEARNED AND RECOMMENDATIONS

- 14.1 Much of what follows is addressed to the Board of the Trust since it is the Board's responsibility to ensure that the lessons that I have identified and the recommendations that I make are considered and, where appropriate, implemented. To the extent that they are relevant, they apply, of course, to the Boards of all Trusts.
- 14.2 I also add a number of matters which are for consideration by the NHS more widely.
- 14.3 I would expect the Board to consider my recommendations and publish its response. I would also recommend that the Board should routinely (every six or twelve months) report publicly on the progress made both in addressing the recommendations and, more generally, in securing care for patients which is both safe and of good quality.

THE BOARD

- 14.4 The Board is made up of Non-Executive and Executive members. What I say here is addressed largely to the Non-Executive members. Because they are Non-Executives, they are not involved, nor should they be, in the day-to-day operational management of the Trust. Thus, in what follows, I set out recommendations relating to structures and processes that should be put in place. Implementation is for the Board, and then for the Executive, answering to the Board. Crucially, therefore, the structure and processes put in place must include ways in which the Board can assess whether the Executive is, in fact, doing what has been agreed.
- 14.5 Much of what I say will already be familiar to the Board. Some of the measures recommended may already be in place. My brief was to identify the lessons that can be learned from what I describe in the Review. Clearly, what I will recommend was **not** in place at the relevant time, or was not properly implemented. If it had been, much of what went wrong would have been avoided.

The Safety and Quality of Care

- 14.6 *It is the Board's primary responsibility to ensure that the care provided to patients is safe and of good quality. To discharge this responsibility, the Board must be engaged. It must not be ignored, side-lined or kept less than well informed. It cannot just be the passive recipient of what the Executive chooses to tell it. It must be able to hold the Executive to account. It must identify a range of information on which it routinely seeks assurance from the Executive. The Board cannot do its duty to serve patients' best interests if important matters are not brought to its attention and if it does not seek to inform itself.*
- 14.7 The safety of patients and the quality of the care that they receive is a matter of fundamental importance to the Board. The Board must agree with the Executive a range of information about the safety and quality of care which must be reported to it and which will inform the Board about the Trust's performance. This information will include matters called for by regulators, but will go further to cover all matters agreed by the Board and between the Board and the Executive.

- 14.8 The Board must publish the range of information that it has agreed upon. It should then publish all the information it receives concerning the safety and quality of the care received by patients on a regular basis. There must be a standing item on the Board's agenda to receive and discuss the information received.
- 14.9 The Board must be active in its pursuit of information about the care of patients and the welfare of staff. It is not sufficient to wait to be advised by the Executive. The Board should also make clear that it can and will call for information on any matter of concern to it.
- 14.10 Part of the process of gaining information on performance is the routine carrying out of audits. The Board must ensure that audits are carried out and that resources are made available for the purpose. The data produced must be made available to the Board and published routinely.
- 14.11 In establishing a suitable framework relating to information, the advice of external agencies should be sought and the experience of high-performing Trusts studied. The Board should routinely receive and comment on the periodic reports of such external bodies as Quality Assurance teams.
- 14.12 To carry out its proper role of scrutiny of the Trust's performance as regards the safety and quality of care, the Board may need to ensure that it has suitably qualified Non-Executive members, who are able rigorously to interrogate the information supplied by the Executive.

Expressing Concerns

- 14.13 Members of staff must be able, and feel able to express concerns about the safety and quality of care provided to patients and be listened to. Clinicians often regard senior management and the Board as remote and barely relevant to their everyday care of patients. This means that when they need to engage the attention of the Trust to address what they see as serious matters, they do not know how to go about it. As a consequence, they may become frustrated and feel ignored, and, as a consequence, become disengaged.
- 14.14 Staff throughout the Trust cannot serve the interests of patients if they choose to be ignorant of the managerial structures of the organisation within which and for which they work. Equally, the Board must ensure that the culture of the organisation is one in which all members of staff know how and with whom to raise concerns and feel safe and comfortable doing so.
- 14.15 When members of staff feel that their concerns are not being addressed appropriately within their organisation, they have a duty to raise them with the relevant professional regulatory body, eg the GMC.
- 14.16 The Board must create an environment in which members of staff feel able and free to raise matters of concern regarding the care and treatment of patients. This involves leadership from the Board and particularly the Chairman. The Chairman must demand of the Board and the Executive a commitment to openness and candour. The extent to which this is reflected in everyday practice must be measured regularly through such devices as surveys of staff and patients. The results of such surveys must be published and reported as a regular item on the Board's agenda.

- 14.17 The Board also has a duty to connect effectively with staff at all levels and require the Executive to do so. The Board must satisfy itself that clinicians and others understand the Board's role and responsibility. It must create ways in which clinicians and other staff can gain access to Non-Executive members, and Non-Executives can gain access to staff. Periodic descents onto wards and the like are not substitutes for genuine engagement, so that staff come to understand the management of the Trust and its relevance to them and their patients.
- 14.18 The concerns of staff can be dealt with best within the relevant team or unit. All staff should be encouraged by managers to raise concerns and must be listened to. Rank, hierarchy, or professional allegiance must not be allowed to stifle the raising of concerns. Any action taken, or the reason for not taking action, must be reported to the team or unit. If the matter meets a criterion of importance agreed between the Board and the Executive, the Board must be notified formally.
- 14.19 The Board must establish and make all staff aware of mechanisms whereby staff can raise concerns if they are reluctant to do so with their colleagues, or feel that they are not being listened to. One mechanism should be the appointment of someone who is completely independent of all managerial control, (some sort of Ombudsman), whose job it is to be available and listen to staff's expressions of concerns. Any such conversations must be confidential. The person appointed should have direct and unrestricted access to the Chief Executive and the Chairman and any other relevant manager so as to convey the concerns. The person appointed should be entitled to request information on what action has been taken and express an opinion on it. Ultimately, the "person appointed" must be entitled to request a meeting of the Board if s/he judges it necessary. In some Trusts, this role has been assigned to the senior independent director on the Board. Though this is a welcome recognition of and response to the problem, it may be that a member of the Board may appear too much a part of the system of management to be seen to be truly independent and to be trusted. Boards in such cases should reflect on whether an appointment in the form that I have set out would be preferable.
The Board and senior management must make it clear that to tolerate unacceptable performance in colleagues is itself unacceptable.
- 14.20 When members of staff are of the view that their concerns are not being addressed appropriately within their organisation, it should be made clear to them that they have a duty to take their concerns to the relevant professional regulator as part of their duty to ensure that the safety and welfare of patients are safeguarded.

Working Formally

- 14.21 The Board's memory and, thus, its capacity to exercise proper governance are impaired if it does not work formally, recording decisions and disseminating them. Failure to do so means that the Board cannot draw on previous experience and existing knowledge, except through the memories of individuals. It means that versions of the past can gain currency without any record to check them against. It also means that operations and projects may not be carefully thought through, with input from all affected, nor appropriately planned and, thus, not well-executed.
- 14.22 The Board must establish formal ways of working in accordance with the requirements of good governance. While informal discussions are a necessary element of management, all matters of substance should be recorded for the benefit of current and future members of staff and Board members, particularly if they relate

to the safety and quality of care provided to patients. Decisions should be recorded and plans set out, with appropriate objectives, resources and timescales. The use of Sub-Committees is a valuable device to distribute the Board's workload, but reports on and concerns about the safety and quality of care must always be brought to and dealt with by the Board. The Minutes of meetings should be published routinely and be sufficiently explicit to allow others to understand what is being discussed and what decisions have been reached. This is one of the fundamental responsibilities of the Chairman of the Board.

Responding to Concerns and Conducting Investigations

- 14.23 The Board should be informed when an investigation is launched. The Board must be made aware of the results of investigations conducted in its name if it is to be able to exercise its responsibilities. Concerns over the safety and quality of care ought not to be investigated through the disciplinary procedures. These procedures should be concerned with personal misconduct. They may be run in parallel but recourse to them as a means of investigating concerns about the safety and quality of care brings a whole apparatus of confidentiality which prevents such investigations from being open. The organisation will only learn necessary lessons if investigations into the safety and quality of care are conducted in an open manner with the engagement of all.
- 14.24 The Trust should ordinarily appoint external experts or the relevant Royal College to carry out investigations into the safety and quality of care. It must also allocate sufficient resources to allow investigations to be completed as promptly and efficaciously as possible. Delays give rise to anxiety in patients and can lead to distrust as to the commitment of the Board. The Governance and Safety Committee, as a sub-committee of the Board, should involve itself in such investigations and be the channel for providing the necessary assurance to the Board concerning the conduct and outcome of them.
- 14.25 The establishment of investigations must be reported to the Board. Thereafter, the Board should receive progress reports on a regular basis. The Board should receive copies of the Reports produced at the end of investigations. These are necessary requirements to enable it to discharge its responsibility. Investigations under the existing disciplinary procedures should be confined to the consideration of personal misconduct by a member of staff. They may run in parallel with but should not be used to investigate concerns about the safety and quality of care provided to patients. The requirements of confidentiality associated with disciplinary procedures must not be used as a means of keeping everyone except a few insiders in the dark. The Board have a right to know what is being done in its name as regards its employees. Members of staff equally are entitled to know what is being done. Lessons cannot be learned and remedial steps taken if nothing is disclosed because of concerns about confidentiality.
- 14.26 The Board must be alert to ensure that Reports which are produced from reviews and investigations are shared widely. The aim must be to avoid piecemeal and disjointed responses and actions. The risk must be avoided that only a few Executives have the relevant knowledge and understanding of the whole picture, making it difficult for other staff and the Board to act effectively. The Board must ensure that proper records are kept, that they are shared with those inside the Trust and with external experts advising the Trust, and are seen by the Board.

- 14.27 In deciding how, in the future, the Board will work with the Executive to address concerns, including the conduct of investigations, the Board should adopt the perspective of the patient rather than that of the clinician/professional. It is important to be fair to the clinician/professional. It is vital to take proper account of the interests of patients. Adopting the perspective of the patient will mean that, when circumstances warrant it, the current approach implicit in the disciplinary procedures, intended to re-integrate the clinician/professional back into practice, should not be adopted. Such an outcome may not, on occasions, be in the interests of patients. To reflect the perspective of patients, the Board should introduce a mechanism for involving one or more patients when addressing concerns or carrying out an investigation regarding the safety and quality of care.
- 14.28 The Governance and Safety Committee is a vital Sub-Committee of the Board. Besides its other responsibilities, it should serve as the channel of communication between the members of staff, the Executive and the Board in the case of investigations and other such matters which relate to the care of patients. In playing this role, the Committee should not limit itself to organisational or structural issues, but also concern itself, where appropriate, with individual cases.
- 14.29 Whenever an investigation is launched, sufficient resources, in terms of funding and people, must be made available so that it can be concluded as quickly and efficiently as possible. Periodic reports on progress should be made to the Board.
- 14.30 Once the examination of concerns or an investigation has been completed, the Board should establish a formal follow-up process to ensure that any lessons have been learned and appropriate action taken.

Communication and Openness within the Trust

- 14.31 It is crucially important that the Board and members of staff are made aware of what is happening in the Trust generally, and as regards their area of activity or responsibility in particular. This is especially so when concerns have been expressed and staff wish to know, and are entitled to know, what is being done. In the absence of accurate information, rumour, gossip and speculation fill the gap. These are very destructive to the morale of staff and of the Trust as a whole. They damage the reputation of the Trust. They undermine the confidence of patients. They create concern and disquiet in the community served by the Trust.
- 14.32 The Board has the responsibility to ensure that the Executive report routinely to it those matters of importance that it has been agreed should be put before the Board. The Board also has the responsibility to ensure that proper mechanisms exist for keeping members of staff informed on developments within the Trust. This is an essential feature of the Board's wider commitment to openness. When concerns have been raised, and when they are being looked into, a commitment to openness means that the Board must have in place procedures whereby members of staff can be kept informed of developments. The requirements of confidentiality in any particular case should not be allowed to keep staff in the dark. While it is important to be fair to those whose conduct is being called into question, this cannot be used as a reason for not keeping staff informed.
- 14.33 The Board should require the Executive to present to the Board the procedures in place to achieve good communication and openness and to report on their operation periodically. The Board must regularly conduct a survey of staff which should ask,

among other things, whether there are matters on which staff wish to be informed or better informed. The results must come to the Board and should serve as one mechanism for holding the Executive to account as regards their leadership of the Trust. The results should be routinely published within the Trust and made available to the public.

- 14.34 The Board must expect of its Executive that it provide the Trust with the necessary operational leadership. Where the leaders are clinicians, the Board must ensure that, as managers, they act as managers. They must not act as clinicians, still part of the system of hierarchies and tribalism which characterises healthcare. Indeed, one of their roles as leaders should be to breakdown these hierarchies as healthcare becomes increasingly a team enterprise. The Board must be vigilant to identify failures in leadership, such as staff feeling bullied, or not listening to unwelcome news. Again, this requires the Board regularly to seek the views of staff and be seen to act on them.

Communication and Openness with Other Bodies

- 14.35 No Trust is an island. Many other bodies are affected by and need to know about what is happening in the Trust. It is part of the Trust's responsibility to keep the wider healthcare community appraised if concerns are being considered which have implications for that community.
- 14.36 It is wrong, as well as pointless, to seek to control the flow of information to outside bodies so as to contain the impact of any particular event or set of circumstances. It prevents others from taking appropriate measures. It ensures that partial information will emerge in an unsystematic manner, thereby damaging patients and the Trust much more than would be the case with full, open communication. And, most important, it is a breach of trust.
- 14.37 The Board must ensure that all relevant agencies are informed when events occur which have implications for the Trust's patients, other patients, or other services. This should form part of the regular report on the handling of concerns which the Board should require of the Chief Executive. Those bodies which may need to know include regulators, commissioners of services, GPs, screening and other such services.
- 14.38 Openness is essential. The Chief Executive's routine report to the Board should include copies of the information provided to all other relevant bodies. This will enable the Board to hold the Executive to account.

Appointment of Consultants and managing them thereafter

- 14.39 The process of appointing consultants is critical if the Trust is to achieve its vision for caring for patients.
- 14.40 It is not easy to challenge and confront improper behaviour or poor performance, particularly if the person to be challenged is an established member of staff. This must not serve as a reason for doing nothing. Failure to confront, or "working around" a difficult colleague or member of staff entrenches problems, sends wrong signals to other members of staff, and puts patients at risk.
- 14.41 Any potential appointee should be shortlisted on the basis of technical skills but appointed on the basis of values. Once appointed, consultants should be supported in their pursuit of care which is safe and of good quality. They must be managed

robustly if there is evidence that they are not caring properly for patients or not working appropriately with colleagues.

- 14.42 A person appointed may be technically sound but have personal qualities or characteristics which mean that s/he will not best serve the interests of patients and the Trust. This may be because of her/his attitudes to colleagues or to patients, or both. Modern healthcare is pre-eminently a team-based exercise. If a person is not a team player, the team is disrupted and the care received by the patient is less than the best.
- 14.43 The process of appointing consultants is traditionally concerned almost exclusively with their technical skills and background. The process should be supplemented by tests designed to identify relevant personality traits, not least collegiality, empathy, and dedication to service and to patients. If a candidate demonstrably lacks these, s/he should not be appointed. The Board must have in place a process which gives effect to this. It may be said that it is hard to recruit in particular fields at particular times, such that anybody is better than nobody. This is not a position which patients would endorse. At the very least, a probationary period can be used during which a consultant can be required to attend appropriate training as a condition of being retained.
- 14.44 A consultant is a leader. S/he trains others, leads teams, represents the unit or team at larger gatherings. If any particular consultant behaves in a way which shows poor leadership, s/he must be confronted immediately and managed robustly. Failure to do so risks putting the care of patients at risk. The Board should satisfy itself that robust procedures exist for identifying and dealing with apparently aberrant behaviour. The notion of “working around” difficult consultants has no place in the NHS. They should be confronted and required to change their behaviour. Their performance should then be monitored and action taken if there is no improvement in behaviour.
- 14.45 The Board must make the Trust’s position clear to every member of staff: that it will not stand for inappropriate behaviour and will provide all necessary support to whomever is responsible for taking action. The Board can only do so if it is made aware of the need. To that end, a mechanism should exist whereby the Chairman is made aware by the Chief Executive in cases where action is not so far having the necessary effect. The member of the Executive responsible for acting must be made aware that a failure to do so will constitute a breach of her/his duty, owed to the Trust and to patients. Those in positions in which they must confront consultants or others as regards their behaviour should receive suitable training and support to carry out what may be a difficult task.
- 14.46 The Board should ensure that disciplinary procedures should be used to deal with matters of personal conduct and inter-personal tensions or conflicts. Their rationale is the re-integration of the professional into the workforce as an effective member. These procedures should not be used when the issues involve the safety and quality of patients’ care, not least because they shroud everything in confidentiality, they inhibit open discussion of disputes which might profit from discussion, they drag on for a long time, and they may make prompt action on behalf of patients difficult to take.

Recall

- 14.47 Though they are uncommon, when they take place, processes for recalling patients are very important for patients, the Trust and all others affected. They must be properly thought through, properly resourced, and properly managed. A number of Trusts have organised recalls and their experience should be taken account of. Patients should be treated with great sensitivity. Good communication and openness are essential.
- 14.48 The Board should commission a short study of other recalls within the NHS to see what can be learned.
- 14.49 The Board should be informed when a decision is made to recall patients. The Board is responsible for the reputation of the Trust and so needs to know. The Board should have in place a process which can be smoothly and promptly adopted in the event that the Trust decides to recall patients. Ideally, the patients recalled should be seen by staff who are not part of the Trust. This engenders confidence in past patients, ensures independent assessment and decisions, allows the Trust to draw on external expertise, and means that the process can be carried out expeditiously. In many cases, the relevant Royal College can be engaged.
- 14.50 Adequate resources, both as regards finance and people, must be allocated.
- 14.51 If staff within the Trust are involved in a recall, they must be supported so that they can give proper attention to it, by, at the very least, being relieved of their routine clinical duties. Enough staff must be deployed to avoid delays. Patients caught up in a recall suffer considerable anxiety. This makes it imperative to move with all due speed.
- 14.52 Once a decision to recall patients is made, the Board should ensure that the decision and the reasoning behind it are communicated promptly and widely to patients, GPs, regulators, other relevant bodies, and the media. The media can assist in the process. Thereafter, the Board should ensure that regular updates are provided internally within the Trust, to patients, and to the media.

Patients

- 14.53 Respect for patients is at the heart of what the Board does and stands for. The perspective adopted when making decisions affecting the care of patients should be the perspective of the patient. Patients are what the Trust exists for: to serve them to the best of its ability.
- 14.54 It is not enough to declare these sentiments in a vision statement and then move on to the business of the day. Caring for patients is the business of every day.
- 14.55 Patients should be treated with respect in their dealings with clinicians. It is crucial that the central importance of seeking patients' consent before treatment is respected. When things go wrong, they must be given honest information, supported in a caring and understanding way, and looked after promptly. Information should be readily available to patients in a range of accessible forms. Lack of information and delays are doubly intolerable when they involve the anxiety of recalls.
- 14.56 The physical environment in which patients are looked after should be designed with the needs of patients as the paramount consideration, rather than the convenience of

the staff or of the organisation. The views of patients should be routinely sought and reported to the Board. Relevant action should be taken in response to these views and made public.

- 14.57 Members of the Board, led by the Chairman, must ensure that the commitment to respect for patients is not empty rhetoric but is reflected in all that is done throughout the Trust, particularly in the way in which they and staff behave. The Board must identify, in consultation with patients, the information about the Trust's performance which allows it properly to assure itself that the needs of patients are at the centre of what the Trust and its staff are doing. This information should be recorded, reported routinely to the Board, and published. The watchword for all staff should be "I exist to provide for you" rather than "This is what I as a professional do and this is where I do it".
- 14.58 The physical environment in which patients are cared for should be reassessed from the perspective of patients. Particular attention should be given to waiting areas, places where bad news can be broken and explored in privacy, the journeys that patients have to make between one source of treatment and another, and to such facilities as coffee machines and drinks dispensers. The Board should convene a group consisting of patients and staff to examine the physical environment and make proposals concerning its possible redesign or development.
- 14.59 Patients are entitled to be told the truth. This applies both to their own condition and to any expression of concerns which touch on their condition or treatment. When there are concerns or developments, such as a change in routine or redeployment of staff, the Board should ensure that the Trust has effective policies in place to ensure that information is provided to patients in a timely and understandable fashion. These policies should be published. The use of plain English, rather than jargon (whether medical or managerial), should be insisted on: jargon excludes the very people whom it is intended to include. The performance of the staff in complying with these policies should be measured and reported to the Board.
- 14.60 The Trust has, by and large, a good system for dealing with complaints. There is room for improvement as regards seeking permission from patients before non-clinicians, or clinicians not associated with their care, have access to patients' notes and records with a view to dealing with complaints, but measures are being taken to address this. The system should operate in all contexts. It should not be impeded by concerns over disciplinary procedures. The Board should adopt a duty of candour as an organisation and ensure, through appropriate measurement, that it is complied with. In meeting this duty, the Board must ensure that complaints and related expressions of concern are dealt with promptly. Unwarranted delay is corrosive of trust and increases anxiety. The Board should have an appropriate performance measure for dealing with complaints with the results reported routinely to the Board and made public.
- 14.61 A central feature of respect for patients is the need to seek their consent before embarking on any treatment. This is both an ethical and a legal requirement. It makes it clear that patients are entitled to have the last word about what happens to their bodies. A growing practice has emerged of talking in terms of "consenting" patients. This is wrong. It trivialises what is a central feature of the relationship between patients and healthcare professionals. It completely undermines the respect that patients are due. It reflects a complete failure of understanding on the part of professionals about the nature of the transaction between them and their patients. It

seeks to reduce a matter of great ethical significance to the level of an administrative chore. The Board must as a matter of urgency address this issue. It is important in its own right and in its symbolic significance about the place of patients. It should issue instructions to the Chief Executive and Medical Directors to take such measures as are appropriate to root out the current practice.

- 14.62 Clinicians confronted by poor care carried out by colleagues should draw it to the attention of others who can take action. To this end, clinicians should ensure that they are familiar with the ways in which concerns can be raised. If they are not satisfied with the response, they should take advantage of the procedure proposed earlier whereby they can escalate their concerns to the independent “person appointed”. While not abandoning patients, the clinicians should not compromise the care they provide so as to compensate for the poor care of colleagues.

THE WIDER NHS

Regulators

- 14.63 Regulators played a passive role as regards the actions of the Trust in addressing concerns about Mr Paterson’s surgical practice, receiving periodic communications when the Trust chose to inform them. To that extent, they denied themselves the opportunity to look more closely at the actions being taken so as to satisfy themselves that they were appropriate to safeguard the interests of patients.
- 14.64 I have made a series of recommendations about how Boards should set out measures of performance as regards the safety and quality of the care provided, which are in addition to those matters currently required of them by statute or regulation, how they should monitor them, how they should routinely publish information on compliance. Regulators should consider how they might incorporate into the standards by which they assess the performance of Trusts, a Trust’s own measures of performance, and its compliance with them. Doing so would enable regulators to be more active. They would be able to track compliance and intervene in an appropriate manner when necessary.

Commissioners of Services

- 14.65 The commissioners of services for breast cancer continued to commission care from HEFT, unaware, at least formally, of growing concerns about Mr Paterson’s surgery. Commissioners of all forms of care need to have up-to-date information about the performance of the services that they commission and of those providing them. If they do not, they may expose patients to the risk of harm. Trusts have a duty to provide that information. They also have a duty to advise commissioners of concerns about any particular area of care, what measures are being taken to address them, and regularly update them.
- 14.66 Commissioners should actively require regular reports on performance from those they commission services from. These reports should include information on compliance with the standards set by the regulators in the area of the safety and quality of care (reflecting the earlier recommendation addressed to regulators). Commissioners must make decisions as to what services to commission, and from which Trust, in the light of information received from the Trust and regulators. Trusts

have a duty to inform commissioners when concerns exist about the safety and quality of care being provided, and to advise what they propose to do. When a Trust launches an investigation into concerns about the care of patients it must advise commissioners and report the outcome.

- 14.67 There should be regular “joined-up” exchanges of information according to agreed protocols between commissioners, regulators, Quality Assurance teams, Royal Colleges, and related organisations in healthcare and social care on the one hand, and Trusts on the other, about the safety and quality of care provided by the Trust.

QA Visits

- 14.68 QA Visits allow for a careful external assessment by experts of elements of a Trust’s performance. Their recommendations are intended to identify matters needing attention and to improve the performance of the service. They can, however, be ignored, since their recommendations are not backed by any sanction for failing to heed them..
- 14.69 To have any real effect, QA Visits should form part of the regime of standards operated by regulators and must be backed by appropriate remedies for non-compliance, including sanctions. Consideration should be given to including the reports and recommendations of QA Visits into the regime of inspection carried out by regulators. Non-compliance could then be identified and appropriate action taken by the regulator.

Disciplinary Procedures and the National Clinical Assessment Agency (NCAS)

- 14.70 Resort to disciplinary proceedings to address concerns relating to the safety and quality of care being provided to patients means that the investigation of those concerns is shrouded in confidentiality, staff immediately affected by decisions may be left in the dark about developments, patients may equally be kept unaware and at risk of being exposed to poor practice, and progress towards resolution is measured in years. Engagement of the NCAS means that the underlying premise is that the issues to be resolved are inter-personal, and that the aim is the re-integration of the clinician into the Trust. The perspective, therefore, is that of the professional, not that of the patient. In cases of concerns about the safety and quality of care this approach is inappropriate.
- 14.71 Disciplinary procedures against a particular clinician are appropriate in appropriate circumstances. Where the issues facing the Trust concern the safety and quality of care, particularly the former, other procedures should be adopted to ensure that the issues are examined openly, promptly and rigorously. They must above all be open. The Board, staff and patients should be kept informed of progress and developments. Any disciplinary procedures should be managed separately or organised in parallel.

Data in the private sector

- 14.72 The assessment of the performance of clinicians and information for the benefit of patients depend on the collection, analysis and dissemination of data. Organisations in the NHS are required to submit data regarding activity and outcome to national and regional databases. There is no parallel obligation on organisations in the private sector to collect or submit such data. This means that patients may not be well-

informed about a particular clinician's overall performance, when s/he works both in the NHS and the private sector. When things go wrong, it may be difficult to determine the scale of the risk that patients are exposed to if the data is incomplete because performance in the private sector has not been reported. Should patients need to be recalled, the process of doing so – whom to recall – is made more difficult and complex.

- 14.73 Organisations in the private sector should be required to submit data on patients to relevant national and local registries: the form of treatment and its outcome. This data should be available to the public. The regulator should make it a condition of registration that organisations in the private sector submit such data.