Report of the Independent Inquiry into the Issues raised by Paterson

Chair: The Rt Revd Graham James, Bishop of Norwich

Terms of Reference

1. A central objective of the Inquiry is to afford former patients of Ian Paterson, and their families, an opportunity to tell of their experiences, and to be heard. The Inquiry will be informed by their concerns and it will examine and seek to learn from what happened to them, both in the independent sector and in the NHS.

2. The Inquiry will consider issues raised in previous relevant reports about Ian Paterson, but does not intend to revisit the evidence that led to his conviction.

3. The Inquiry will review the circumstances and practices surrounding Ian Paterson as a case study, and consider other past and current practices, so as to draw conclusions in relation to the safety and quality of care provided nationally to all patients.

The issues it will consider include:

A. a comparison of the accountability and responsibility for the safety and quality of care received between the independent sector and in the NHS; including the roles of hospital providers and others in appraising, reporting, considering concerns and monitoring as regards healthcare professionals' activity levels, conduct and performance;

B. how and when information is shared between the NHS, independent sector, and others, including concerns raised about performance and patient safety;

C. the arrangements for assuring that healthcare professionals maintain appropriate professional standards and competence, including appraisal, revalidation, scope of practice, and the role of hospital providers, professional and quality regulators, and other oversight bodies;

D. MDT working, including a comparison of practice in the NHS and the independent sector;

E. the role of independent sector insurers, medical indemnifiers and medical defence organisations (including sharing of data);

F. the arrangements for medical indemnity cover for healthcare professionals in relation to all patients receiving care in the independent sector, whether such patients are medically insured or their treatment is NHS-funded or self-funded;

G. the means by which patients are referred from the NHS to the independent sector by individual healthcare professionals, including the role of NHS waiting times in relation to that practice;

H. the adequacy of the response to patients following adverse incidents, including clinical recall, in both the independent sector and the NHS; and

I. any other significant matters that may arise during the course of the Inquiry.

4. The Inquiry will be restricted to matters concerning the treatment of patients in the independent sector and the NHS in England.

5. The Inquiry will:

A. produce a report which will provide an overview of the information it has reviewed, and which will set out any findings of fact it has made and its recommendations;

B. compile an annex to the report detailing the experiences of patients and their families; and

C. if information is obtained in the course of the Inquiry, report any instances of apparent collusion or other conduct of concern (including conduct that indicates the potential commission of criminal or disciplinary offences) to the relevant employer(s), professional or quality regulator(s), and/or the police for their consideration. The Inquiry does not have the power to impose disciplinary sanctions or make findings as to criminal or civil liability.

Report Contents

The report is 238 pages long.

The first two sections give an introduction to the background and the format of the Inquiry.

The third chapter is a chronological series of patient / family member accounts from patients of Paterson from the early 1990s to the early 2010s. 211 people told the Inquiry about their experience as a patient of Paterson or about the experience of a member of their family who had been treated by him. Of the patients themselves, 80 were treated in the NHS, 92 were treated in the independent sector and five were NHS patients treated in the independent sector.

The report then considers four specific areas:

Safety and quality of care

Responding when things go wrong

Working with others to keep patients safe

Governance, accountability and culture

The summaries of each section and the report recommendations are summarised below:

Safety and quality of care

The care patients received from Paterson was not always safe or appropriate. The CSMs he performed were not acceptable clinical practice.

In many cases, patients had treatment that was not complete, or necessary, or which was harmful, and this led to long-term avoidable health issues and may have contributed to some deaths.

We also heard accounts of cases where Paterson performed surgeries and procedures which he was not qualified to do or was restricted from doing.

Paterson manipulated and lied to people. He broke the rules to facilitate his malpractice.

Paterson often failed to obtain consent from his patients, and then did not properly discuss their treatment with other healthcare professionals.

Checks and balances designed to ensure safety of care at the hospitals where Paterson practised were inadequate or were not followed, and this allowed him to continue with unsafe and unnecessary treatment which harmed patients.

Checks and balances which have been put in place since Paterson practised, and which may have detected his malpractice, are not universal or uniform across the NHS and independent sectors. It is our opinion that it remains possible for poor or unsafe practice to be undetected today.

Responding when things go wrong

When things go wrong, the response should be swift, adequate and ensure that patients are safe. There were a series of failures to respond well – in both Spire and HEFT – and a sense of responsibility to do the right thing for patients was lacking.

Patients felt that both their recall and the reaction to their complaints were dealt with too slowly.

It was difficult for patients to raise concerns at HEFT and with Spire. There was a lack of information and transparency to support them in doing so. Routes to escalate concerns were not visible to patients.

The response to patients who raised concerns was inadequate in both sectors. It was defensive, not patient-focused on an individual basis, and did little to recognise the distress, worry and anger patients were experiencing.

There is inequity between patients treated in the NHS, who have a right to escalate a complaint to the Ombudsman for independent investigation, and private patients treated in the independent sector, who do not have this right. Moreover, private patients appear to be unaware that they do not have this level of protection.

Opportunities to stop Paterson practising in response to concerns raised by healthcare professionals in the NHS were missed on a number of occasions, and for a sustained period of time. Connections were not made between individual incidents, to the detriment of patient safety.

There is a strength of feeling amongst healthcare professionals that raising concerns will come at a personal cost to them. This perception continues, despite recent measures to empower and protect healthcare professionals and other staff who raise concerns.

The recall of patients was generally inadequate, not-patient focused, and lacked transparency in both the NHS and independent sector. Due consideration wasn't given to patients' emotional and psychological needs in either sector, and the particular needs of patients who were wrongly diagnosed with cancer by Paterson at Spire were ignored.

We are not convinced that all patients who should have been recalled have been contacted. UHB has gone some way to rectifying this by reviewing all Paterson's surviving mastectomy patients and providing them with ongoing care, where necessary. This has not been replicated by Spire.

There is a lack of guidance to the healthcare sector on good practice when recalling patients for review of their care following adverse incidents.

Many patients made claims for compensation as a last resort. They had mixed experiences in doing so. In the NHS, claims were settled quickly, with liability sorted out in the background. This was not the case in the independent sector where disputes about who was liable delayed payments being made to patients, causing them further distress. There is no safety net for private patients in the independent sector where indemnity cover for doctors is discretionary.

The MDU used its discretion to withdraw cover in relation to Paterson because his malpractice was deemed criminal activity. This was a failing of the system to provide adequate support to patients when they had been through significant trauma.

Private medical insurance companies funding care for patients at Spire, told us that they did not and could not spot any concerns about Paterson from the data they collect. We were surprised by this, given the high number of procedures and diagnostic tests he carried out in a single hospital.

Working with others to keep patients safe

Whilst things have improved in relation to sharing concerns and sharing information since the time of Paterson, and continue to do so, it would be wrong to say that systems in place today would identify and stop another Paterson at an early stage.

The information shared about private healthcare has improved but is still limited in scope, not universally submitted by all private healthcare providers, is not available to the public and cannot currently be easily compared alongside NHS data.

There were many instances where information was either not shared with the GP or between providers, or the information was incomplete, making it difficult to identify concerns.

There is still some confusion as to when concerns should be shared and what the threshold should be.

The responsible officers' framework is more likely to result now in sharing issues, but the independent sector told us the NHS was poor in relaying concerns to them.

The independent sector is not considered in national patient safety plans and initiatives and is excluded from submitting data alongside NHS providers for many national clinical audits, clinical registries and other national data collections.

There are barriers to information sharing, including information governance considerations, commercial sensitivity and differing standards which need to be overcome.

The healthcare system is regulated by the CQC, NMC and GMC. However, despite this regulated landscape, Paterson's malpractice continued over a sustained period within the context of concerns being known about him at HEFT since 2003. All the regulators appeared to be waiting for someone else to act. It is our view that in this case, the regulation of the healthcare system failed.

The regulators (GMC, NMC, CQC) and the PSA have told us that it is less likely to happen now. From the evidence we have heard, it is our opinion that this is not the case.

The roles of the different regulators need to be more clearly explained to the public and each should improve its patient focus and ensure better signposting of patients to the appropriate body.

Governance, accountability and culture

The boards of HEFT and Spire were remote from front-line healthcare professionals and patients when Paterson was practising, and for some years afterwards.

Clinical leadership at board level is lacking in listed companies operating in the independent sector.

Paterson could have been stopped from practising in 2003, and should have been stopped in 2007 rather than 2011.

There is inequity in the treatment of patients at Spire Parkway and surviving mastectomy patients treated at HEFT. Patients treated at HEFT have had a review of their case, had this communicated to them and have been provided with ongoing care, if necessary. This has not been the case for patients treated at Spire Parkway.

Paterson exploited patients' fear of waiting for treatment and their fear of having cancer. There was little information available to patients to help them understand the reality of how long they would need to wait for NHS treatment.

Paterson behaved in ways that were not acceptable or were inappropriate in a hospital or clinical setting. This behaviour appears to have been tolerated and we did not hear evidence that he was challenged by some healthcare professionals who should have done so.

There was a lack of curiosity about Paterson from his colleagues and those in charge of HEFT and Spire for a sustained period of time. This had devastating consequences for patients.

Recommendations

We note that there were many regulations and much guidance in place during Paterson's years of practice. It is significant that a lot of these were disregarded or ignored by Paterson and others. There is no single legislative or regulatory fix which would ensure safety for all patients in the future. In making these recommendations, we assume that existing regulations and guidance will be followed and enforced. The recommendations which follow arise from evidence that we have heard in the course of the inquiry.

Information to patients

We heard from patients that much of the information they received about Paterson was unreliable, and the result of hearsay and an inflated local reputation. Patients had no means of independently testing or verifying the information they received. We heard that patients would welcome a single source of information relating to each consultant's practice. This was endorsed by a significant number of witnesses, including those who had a managerial or clinical responsibility for consultants.

Recommendation 1

We recommend that there should be a single repository of the whole practice of consultants across England, setting out their practising privileges and other critical consultant performance data, for example, how many times a consultant has performed a particular procedure and how recently. This should be accessible and understandable to the public. It should be mandated for use by managers and healthcare professionals in both the NHS and independent sector.

Government response – accept in principle

Significant progress has been made on the collection of consultant performance data in the independent sector and the NHS. In 2018, the Acute Data Alignment Programme (ADAPt) was launched to move towards a common set of standards for data collection, performance measure methodologies and reporting systems across the NHS and the independent sector, with potential to be fully implemented by 2022 to 2023.

This data will be made available for managers and healthcare professionals across the system to help support learning and identify outliers.

Over the next 12 months, we commit to reaching a decision with key stakeholders on what information can be published and whether further government action will be needed to achieve this.

Patients told us that Paterson had given information about them in the letters he sent to GPs which was different from what he had said at their consultation, but they had not seen these letters at the time. Such letters are routinely sent to GPs after consultation or treatment but are not always written in a way which is easy to understand.

Recommendation 2

We recommend that it should be standard practice that consultants in both the NHS and the independent sector should write to patients, outlining their condition and treatment, in simple language, and copy this letter to the patient's GP, rather than writing to the GP and sending a copy to the patient.

Government response – accept

Guidance across the healthcare system now states that consultants should write directly to patients and in a way that they understand. Key stakeholders have committed to writing to their members to encourage uptake.

Over the next 12 months, we will explore with providers how their systems can change to make the process of writing to patients easier for healthcare professionals and how this can be monitored.

There are differences in how the NHS and the independent sector are organised. In the independent sector, consultants are not usually employed by the private hospitals, and have to make their own arrangements for clinical indemnity. In addition, most private hospitals do not have intensive care units on site. Patients who require intensive care, or have need for emergency treatment, are usually transferred to an NHS hospital. These differences were not apparent to patients who spoke to the Inquiry at the time they chose to be treated privately by Paterson.

Recommendation 3

We recommend that the differences between how the care of patients in the independent sector is organised and the care of patients in the NHS is organised, is explained clearly to patients who choose to be treated privately, or whose treatment is provided in the independent sector but funded by the NHS. This should include clarification of how consultants are engaged at the private hospital, including the use of practising privileges and indemnity, and the arrangements for emergency provision and intensive care.

Government response – accept

The government will commission the production of independent information to make people aware of the ways in which their private care is organised differently from the arrangements in the NHS. Created in partnership with patients, families and carers, this will

be published in 2022 and will include expert views on a range of relevant areas that are backed by data and evidence.

Consent

We heard that patients often felt under pressure to decide to go ahead with surgery. Their options for treatment, including the risks associated with any procedure, were not explained clearly to them before they gave consent for surgery. This was out of line with existing guidance, which sets out that patient consent must be voluntary, informed, and that the patient must have the mental capacity to understand what they are consenting to. Even in the case of patients who need surgery quickly, the Inquiry's clinical panel advised us that patients need a short period of time to reflect on their diagnosis and treatment options to ensure they are giving informed consent for their treatment. We understand that the GMC is also considering this issue.

Recommendation 4

We recommend that there should be a short period introduced into the process of patients giving consent for surgical procedures, to allow them time to reflect on their diagnosis and treatment options. We recommend that the GMC monitors this as part of 'Good Medical Practice'.

Government response – accept in principle

Many key organisations, including the General Medical Council (GMC), have taken steps to update their guidance and to confirm that doctors should give patients sufficient time to consider their options before making a decision about their treatment and care.

During annual appraisals, doctors must provide supporting information to demonstrate that they are continuing to meet the principles and values set out in 'Good medical practice'. The Care Quality Commission (CQC) takes all GMC guidance into account during its assessments.

Multidisciplinary team (MDT)

Every patient with breast cancer should have their case discussed at an MDT meeting, in line with up-to-date national guidance. CQC considers this as part of the "safe" and "effective" domains of its inspection framework for independent hospitals providing acute service. We heard that while Paterson was practising at Spire, decisions about patients' treatment were not discussed at properly constituted MDT meetings. Independent sector providers have told us of changes they have made to improve compliance with guidance in this area. We also heard that patients who are treated in the independent sector may have their treatment discussed at MDT meetings in the NHS, but that the quality of those discussions varied.

Recommendation 5

We recommend that CQC, as a matter of urgency, should assure itself that all hospital providers are complying effectively with up-to-date national guidance on MDT meetings, including in breast cancer care, and that patients are not at risk of harm due to non-compliance in this area.

Government response – accept

CQC has now added more detailed and specific prompts on multidisciplinary teamworking to the inspection framework for diagnostic imaging services in NHS and independent acute hospitals, including reference to NHS England and Improvement (NHSEI)'s guidance on streamlining multidisciplinary team meetings for cancer alliances.

When assessing providers in the NHS and the independent sector, CQC will continue to seek assurance that patients are not at risk of harm due to non-compliance with this guidance.

Complaints

Patients we saw who were treated in the NHS were not satisfied with HEFT's response to their complaints, and did not appear to know about the role of the Parliamentary and Health Service Ombudsman (PHSO). Private patients treated in the independent sector have no recourse to the PHSO and are directed to the Independent Sector Complaints Adjudication Service (ISCAS), if their hospital subscribes to the service. Private patients did not appear to know of this option. If the hospital does not subscribe to ISCAS, the patient will not have access to independent investigation or adjudication of their complaint.

Recommendation 6a

We recommend that information about the means to escalate a complaint to an independent body is communicated more effectively in both the NHS and independent sector.

Government response – accept

The Parliamentary and Health Service Ombudsman (PHSO) is currently piloting the NHS Complaint Standards, which set out in one place the ways in which the NHS should handle complaints, including the need for organisations to ensure that people know how to escalate to the Ombudsman. These have been developed with the Independent Sector Complaints Adjudication Service (ISCAS), who have included it in their code of practice.

We will continue to work closely with key organisations involved to ensure that standards are reinforced.

Recommendation 6b

We recommend that all private patients should have the right to mandatory independent resolution of their complaint.

Government response – accept in principle

CQC will strengthen its guidance to make clearer that it expects to see arrangements in place for patients to access independent resolution of their complaints regarding independent sector providers.

We will review uptake across the independent sector in the next year, and if uptake is not widespread, we will explore whether current legislation needs to be amended to ensure that all providers make provision for independent adjudication.

Patient recall and ongoing care

We recognise that when Paterson was operating, Solihull Hospital was run by Heart of England NHS Foundation Trust (HEFT). However, the following recommendation is about the current and ongoing care of patients treated by Paterson, so it is addressed to University Hospitals Birmingham NHS Foundation Trust and Spire (UHB). Although there have been assurances from both the Trust and Spire that they have recalled all patients who needed to be, we heard from almost a third of patients who gave evidence to the Inquiry that they have never received communication about recall or attended an appointment. We heard from relatives of deceased patients who had not been given information about the appropriateness of their care. We note that the Trust reviewed, in 2015, all surviving patients of Paterson who had a mastectomy at HEFT. The aim of the Trust's review was to provide advice for each individual patient on the adequacy of their care, and to recommend appropriate follow-up. Patients who had a mastectomy at HEFT have a care plan, where necessary, funded by the NHS. To date, we heard from patients that there has not been an ongoing treatment plan appropriate to their health needs at Spire, although Spire do not accept this.

Recommendation 7

We recommend that the University Hospitals Birmingham NHS Foundation Trust board should check that all patients of Paterson have been recalled, and to communicate with any who have not been seen.

Government response – accept

By August 2020, University Hospitals Birmingham NHS Foundation Trust had contacted all known living patients of Ian Paterson.

By the end of June 2021, the trust had ensured that all known former patients had had their care reviewed, and that any outstanding concerns were addressed in a way that was determined by the patient.

Recommendation 8

We recommend that Spire should check that all patients of Paterson have been recalled, and to communicate with any who have not been seen, and that they should check that

they have been given an ongoing treatment plan in the same way that has been provided for patients in the NHS.

Government response – accept

By December 2020, Spire had proactively contacted all known living patients of Ian Paterson to check that their care had been fully reviewed, and that they were getting any ongoing support and treatment that they needed.

Spire have now reviewed the care of over two-thirds of the patients concerned. Spire have prioritised the review of patients according to clinical need, with the most likely in need of new intervention being reviewed first.

We have asked Spire to provide the Department of Health and Social Care (DHSC) with an update on progress in 12 months' time.

Improving recall procedures

We heard from patients recalled by both HEFT and Spire that their experience of recall was generally inadequate, not patient-focused, and lacked transparency. Patients were often treated as a problem to be solved during the recalls. We also heard that there were no national guidelines to follow at the time, and we understand that this is still the case today.

Recommendation 9

We recommend that a national framework or protocol, with guidance, is developed about how recall of patients should be managed and communicated. This framework or protocol should specify that the process is centred around the patient's needs, provide advice on how recall decisions are made, and advise what resource is required and how this might be provided. This should apply to both the independent sector and the NHS.

Government response – accept

A national framework has been developed that outlines actions to be taken by organisations in both the NHS and the independent sector in the event of a patient recall. The National Quality Board (NQB) will own the framework, which will be published in 2022 and periodically updated.

Clinical indemnity

Medical defence organisations cover the costs of claims and damages awarded to patients. However, they are not subject to financial conduct regulation, and the indemnity cover they provide is discretionary. The Medical Defence Union used its discretion to withdraw cover since Paterson's activity was criminal. This left patients without cover. In the event of the

medical defence organisation and the hospital failing to provide cover, some witnesses thought there was a need to provide an industry-wide "safety net" so that patients are not left uncompensated. Other witnesses noted that the current system of indemnity cover for consultants working in the independent sector is unregulated, and told us that it should be regulated.

Recommendation 10

We recommend that the Government should, as a matter of urgency, reform the current regulation of indemnity products for healthcare professionals, in light of the serious shortcomings identified by the Inquiry, and introduce a nationwide safety net to ensure patients are not disadvantaged.

Government response – pending

In 2018, the government launched a consultation on appropriate clinical negligence cover for regulated healthcare professionals. This sought views on whether to change legislation to ensure that all regulated healthcare professionals in the UK not covered by state indemnity hold regulated insurance, rather than discretionary indemnity.

The government has now extended this programme to consider the issues raised by the inquiry and is committed to bringing forward proposals for reform in 2022.

Regulatory system

In 2018/19, the Care Quality Commission, the General Medical Council and the Nursing and Midwifery Council, had a total annual budget of over £435m per year, and between them employed over 5,200 people. In addition to this, the Professional Standards Authority for Health and Social Care employed a further 40 people with an annual budget of £4m, raised by fees paid by the regulatory bodies it oversees. Despite the scale of the regulatory system, it does not come together effectively to keep patients safe. We also heard that it is not accessible or understood by patients. We do not believe that the creation of additional regulatory bodies is the answer to this.

Recommendation 11

We recommend that the Government should ensure that the current system of regulation and the collaboration of the regulators serves patient safety as the top priority, given the ineffectiveness of the system identified in this Inquiry.

Government response – accept

System and professional regulators have an overarching statutory objective to protect, promote and maintain the health, safety and wellbeing of the public.

The healthcare regulators referenced in the inquiry (GMC, Nursing and Midwifery Council (NMC), and CQC) exist to protect patient safety and this is reflected in their new corporate

strategies. They have also taken a number of actions to encourage information-sharing between organisations and to enable patients and professionals to raise concerns.

DHSC's 2021 consultation regulating healthcare professionals, protecting the public sets out proposals that address the issues raised in the inquiry, including a proposal to place a duty to co-operate on all regulators. DHSC plans to draft legislation in relation to the GMC in 2022.

Investigating healthcare professionals' practice and behaviour

We heard from senior managers and healthcare professionals in both the NHS and the independent sector that Paterson could and should have been suspended by HEFT earlier than he was, given that concerns first began to be raised in the early 2000s. HEFT used the HR process to investigate him, even though the concerns relating to Paterson from 2003 related to his clinical practice. Goldman told us that he was following legal advice and existing guidance in investigating the concerns, using an HR process. We also heard that some of the healthcare professionals who had raised concerns at HEFT in 2007, and who worked alongside Paterson at Spire, did not tell Spire about the concerns until Paterson was suspended in 2011. Goldman told us that he felt he acted appropriately in response to the concerns raised.

Recommendation 12a

We recommend that if, when a hospital investigates a healthcare professional's behaviour, including the use of an HR process, any perceived risk to patient safety should result in the suspension of that healthcare professional.

Government response – do not accept

We agree that exclusions and restriction of practice can be necessary, and in some cases immediate exclusion is an appropriate response while an investigation is ongoing. However, we do not believe it would be fair or proportionate to impose a blanket rule to exclude practitioners in such cases. Such a step may inadvertently cause a chilling effect, dissuading healthcare professionals from raising concerns and negatively impacting patient safety.

It is vital that investigations are robust and conducted in a timely manner. Guidance has been put in place to ensure that concerns are taken seriously, appropriate action taken and that robust investigation processes are implemented, and that clarity on when to exclude a healthcare professional is provided.

Recommendation 12b

If the healthcare professional also works at another provider, any concerns about them should be communicated to that provider.

Government response – accept in principle

The government agrees that, where patient safety is at risk, information should be shared with other providers. However, there must be an element of judgement by providers as they will be taking on responsibility to ensure that this information is appropriate and accurate. Regulators have taken key steps to make it easier for people and organisations to share information regarding patient safety risks. The Medical Profession (Responsible Officers) Regulations 2010 (revised in 2013), which apply to all medical practitioners, have also set out prescribed connections for sharing information regarding performance concerns between health organisations.

Corporate accountability

We heard that many patients treated at HEFT, and many treated at Spire, did not feel that the hospitals took responsibility for what had happened. In the NHS, consultants are employees and the NHS hospital is responsible for their management, and accepts liability when things go wrong. The situation is very different in the independent sector where most consultants are self-employed. Their engagement through practising privileges is an arrangement recognised by CQC. However, this recognition does not appear to have resolved questions of hospitals' or providers' legal liability for the actions of consultants.

Recommendation 13

We recommend that the Government addresses, as a matter of urgency, this gap in responsibility and liability.

Government response – accept in principle

The government is clear that independent sector providers must take responsibility for the quality of care provided in their facilities, regardless of how the consultants are engaged.

The Medical Practitioners Assurance Framework (MPAF), published in 2019 by the Independent Healthcare Provider Network (IHPN), was created to improve consistency around effective clinical governance, and to set out provider and medical practitioner responsibilities in the independent sector.

CQC will continue to assess the strength of clinical governance in providers as part of its inspection activity, taking account of relevant guidance such as the MPAF.

As covered in our response to recommendation 10, we have set out a programme of work that will consider the case for reforms to the provision of indemnity cover. We will use this as our initial approach to dealing with the challenges faced by patients of Ian Paterson in accessing compensation.

We also heard that patients felt that they did not receive any meaningful apology from the hospitals. We understand that apologising was conflated with admitting legal liability. Despite the historical guidance on being open and saying sorry and, more recently, the statutory Duty of Candour, we were provided with no evidence to show how boards accept and implement accountability for apologising.

Recommendation 14

We recommend that when things go wrong, boards should apologise at the earliest stage of investigation and not hold back from doing so for fear of the consequences in relation to their liability.

Government response – accept

Healthcare organisations have a statutory duty of candour, which sets out specific requirements providers must follow when things go wrong with care and treatment, including providing truthful information and an apology. This duty is regulated by CQC.

NHS Resolution has consistently advised its members to apologise when things go wrong and to provide a full and frank explanation at the earliest possible stage, irrespective of the possibility of a legal claim. More work is underway to ensure that this NHS Resolution guidance is promoted.

Adoption of the Inquiry's recommendations in the independent sector

We heard from witnesses that, while the independent sector shares a regulatory system with the NHS, it has a different governance model. Therefore, it is not possible for the Government to require the independent sector to implement all the recommendations it accepts. Where good practice is implemented in the NHS, it is often voluntary in the independent sector. Where the independent sector does adopt best practice, it is often slow and decisions to adopt such practice focus on innovation and flexibility, rather than keeping patients safe.

Recommendation 15

We recommend that, if the Government accepts any of the recommendations concerned, it should make arrangements to ensure that these are to be applicable across the whole of the independent sector's workload (i.e. private, insured and NHS-funded) if independent sector providers are to be able to qualify for NHS-contracted work.

Government response – do not accept – keep under review

This recommendation, if implemented, would change the way in which independent sector providers qualify for NHS contracts. As demonstrated in our response to the other recommendations, independent sector providers are fully committed to implementing changes alongside NHS providers. They must already meet the same regulatory standards, as required by CQC.

We will continue to monitor the independent sector uptake of the other recommendations and we will review our position on this recommendation in 12 months' time, setting out further steps if necessary.

Mark Sibbering January 2022