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Health and Social Care Committee

Expert Panel: Evaluation of the Government's progress on meeting patient safety recommendations

Second Special Report of Session 2023-24

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Health and Social Care Committee

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The Committee's Expert Panel

1. In 2020, we established and commissioned a panel of expert specialist advisors (known as the Committee's Expert Panel or the "Expert Panel") to evaluate—independently of us—progress the Government has made against its own commitments in different areas of healthcare policy. The framework for the Panel's work was set out in our Special Report, *Process for independent evaluation of progress on Government commitments* (HC 663), published on 5 August 2020. The Expert Panel has previously published six evaluations on the Government's progress against policy commitments relating to services for maternity, mental health, cancer, and pharmacy; and the health and social care workforce and NHS digitisation.[1]

2. The Core members of the Expert Panel are Professor Dame Jane Dacre (Chair), Professor Emma Cave, Professor Anita Charlesworth CBE, Sir Robert Francis KC,[2] Sir David Pearson and Professor Stephen Peckham.

3. We asked our Expert Panel to undertake its seventh evaluation on progress in implementing those recommendations made by public inquiries and reviews on patient safety which the Government had accepted.

4. To enable the Panel to evaluate the Government's progress in implementing patient safety recommendations, which were made by independent inquiries and reviews and accepted by the Government, we agreed to the Panel's modification of its usual evaluation methodology.[3] These changes were necessary because in previous evaluations the Panel has assessed Government commitments. Further details are provided in the Expert Panel's evaluation of patient safety recommendations, which is appended to this Report.

5. We thank the members of our Expert Panel for their work and the important contributions they have made in support of the Committee's scrutiny of the Department of Health and Social Care.

The Expert Panel's evaluation

6. With our agreement, the Expert Panel focussed on the following areas:

- maternity care and leadership
- training of staff in health and social care
- culture around patient safety and whistleblowing

1 Maternity services in England, published on 6 July 2021 (HC 18); Mental health services in England, published 9 December 2021 (HC 612); Cancer services, published on 30 March 2022 (HC 1025); the health and social care workforce, published 25 July 2022 (HC 112); the digitisation of the NHS, published 17 February 2023 (HC 780); and pharmacy services, published 25 July 2023 (HC 1310).

2 Sir Robert did not take part in the work on this evaluation due to prior involvement in some of the inquiries and reviews that produced recommendations the Panel was to assess.

3 The Panel's usual methodology is set out in our Special Report, Process for independent evaluation of progress on Government commitments published on 5 August 2020 (HC 663).

7. We append to this Report our Expert Panel's evaluation of Government's implementation of patient safety-related recommendations made by independent inquiries and reviews and look forward to the Department's response to it within two months of publication.

The Health and Social Care Committee's Expert Panel:

Evaluation of the Government's progress on meeting patient safety recommendations

Introduction

When a major patient safety incident occurs, an independent inquiry or review is sometimes established by the Government to determine the facts, to highlight where failings have occurred and to make recommendations about how systems can avoid similar incidents reoccurring. There is not a formal mechanism for systematically scrutinising or tracking Government progress in implementing the recommendations it has accepted following such inquiries or reviews. For this reason, formal processes of evaluation and review are important, not only to hold the Government to account, but to allow those responsible for the implementation of recommendations to critically appraise their own progress, and to identify areas for future focus, and to foster a culture of learning and improvement.

Improvement and review are iterative processes during which the impact and success of innovations are identified, modified, and reviewed, and this discipline is already in good use within the NHS. The concept has also been used successfully in health and social care by the Care Quality Commission (CQC). To apply this approach to health policy, the House of Commons Health and Social Care Select Committee established a panel of experts to support its role in scrutinising the work of the Department for Health and Social Care. The Expert Panel (hereafter referred to as the Panel) is chaired by Professor Dame Jane Dacre and is responsible for conducting politically impartial evaluations of Government commitments in different areas of healthcare policy. In the present case, the Panel has conducted an evaluation of the Government's implementation of inquiry and review recommendations that it has accepted. The Panel's evaluations are independent from the work of the Committee.

The Panel produces a report after each evaluation which is sent to the Committee to review. The Panel's report is independent of the Committee's report of its own activity within the same policy area. The report of the Panel includes a rating of the progress the Government has made against achieving its own commitments, or in the present case, in implementing the recommendations it has accepted. The ratings are based on the "Anchor Statements" (see Annex A) set out by the Committee. The intention is to identify instances of successful implementation of Government pledges in health and social care as well as areas where improvement is necessary, and to provide explanation and further context.

The overall aim is to use this evidence-based scrutiny to feed back to those making promises so that they can assess whether their commitments (or in this case, the implementation of recommendations the Government has accepted) are on track to be met and to ensure support for resourcing and implementation was, or will be, provided to match the Government's aspirations. It is hoped that this process will promote learning about what makes an effective commitment or recommendation, identify how Government implementation of its promises are most usefully monitored, and ultimately improve health and care.[4]

Where appropriate, the Panel will revisit and review policy areas to encourage sustained progress. The present evaluation returns, in part, to the policy area of maternity care,

4 During a roundtable with stakeholders during a previous evaluation, we heard that the term "service user" was not a preferred term in the social care sector, and that we should instead refer to those receiving social care as "people in receipt of social care". We have therefore chosen to do so in the text, but quotes and statistics which use the term "service user" will appear in the text where they have done so in the original sources.

which was the subject of the Panel's very first evaluation.[5] The Panel's remit is to assess progress against the Government's key commitments (or in this case, accepted inquiry or review recommendations) for the health and care system, rather than to make policy recommendations.

This is the seventh report of the Panel. It evaluates the Government's implementation of recommendations of independent inquiries and reviews that it has accepted, within the area of patient safety.

Members of the Expert Panel

The Panel is chaired by Professor Dame Jane Dacre DBE. For this evaluation subject specialists were consulted in a roundtable event.[6] All Panel members are appointed as specialist advisors by the House of Commons Health and Social Care Select Committee.

Core members of the Panel are:

- Professor Emma Cave
- Professor Anita Charlesworth CBE
- Sir David Pearson, and
- Professor Stephen Peckham.
- Sir Robert Francis KC. Sir Robert did not take part in the work on this evaluation due to prior involvement in some of the inquiries and reviews that produced recommendations the Panel was to assess.

Further information on the Panel is set out in the Health and Social Care Committee Special Report: Process for independent evaluation of progress on Government commitments (5 August 2020).[7] The latest information relating to the Expert Panel can be found here: The Health and Social Care Committee's Expert Panel (shorthandstories.com).

Expert Panel secretariat

- Maria Amrin
- Sandy Gill
- Fergus Reid
- Yohanna Sallberg
- Emma Stevenson
- Professor Katherine Woolf
- Catherine Wynn

5 The Health and Social Care Committee, The Health and Social Care Committee's Expert Panel: Evaluation of Government commitments in the area of maternity services in England HC 18 (July 2021)

6 Expert Panel roundtable - group 2

7 The Health and Social Care Select Committee, Process for independent evaluation of progress on Government commitments HC 663 (August 2020)

Acknowledgements

We would like to thank the Department of Health and Social Care and NHS England (NHSE) for their engagement with our evaluation. We would like to extend our thanks to those who have supported our work, and especially those who took part in our roundtable discussions. The testimonies they provided have been a great asset in our evaluation process, and we thank them for their involvement and their candour. We would also like to thank the various organisations, interest groups and individuals who provided written evidence to our evaluation, and for the quality and detail of their submissions. These submissions made a significant contribution to the Panel's evaluation of the Government's implementation of patient safety independent inquiry and review recommendations, which it has accepted.

Executive Summary

The Health and Social Care Committee (hereafter 'the Committee') commissioned us to evaluate the implementation of recommendations made by inquiries and reviews into patient safety which had been accepted by the Government. This report has been produced independently of the Committee's inquiry into NHS leadership, performance and patient safety. The findings and ratings, however, may contribute to the Committee's inquiry on this area.

The Expert Panel consists of specialists with recognised expertise in quantitative and qualitative research methods, and policy evaluation. The evaluations and judgements made by the Expert Panel in this report are summarised by ratings which assess the Government's progress against a specific selection of accepted patient safety recommendations.

The ratings in this report are in the style used by national bodies such as the CQC, however they have been determined by us and do not reflect the opinion of the CQC or any other external agency. The recommendations under review are interconnected, allowing an overall rating to be made which forms a combined assessment against all the recommendations we evaluated. Separate ratings have also been given to each recommendation and its main components. All ratings are informed by a review process using a combination of established research methods, expert consensus, and consultation with communities.

Our approach to this evaluation was to review quantitative and qualitative data provided by the Department and relevant non-departmental public bodies invited to contribute to the evaluation, alongside relevant research evidence to establish causative links, as well as evidence from other sources via a call for written submissions. We also heard from health and social care professionals, patients, researchers, people in receipt of social care and advocates. Sources are referenced in footnotes throughout the report.

Selected recommendations

The Department for Health and Social Care provided us with a list of independent public inquiry and review recommendations pertaining to patient safety and whistleblowing in the NHS that that the Government has accepted since 2010.[8] Using this information and wider policy documentation, we identified five recommendations across three broad policy areas to evaluate, in order to provide an overview of the Government's progress. These included important and measurable ambitions for patient safety in England. We evaluated the Government's progress against these recommendations:

8 Letter from the Parliamentary Under-Secretary of State Maria Caulfield MP to the Chair of the Health and Social Care Committee and Jane Dacre, 27 November 2023

Policy Area	Accepted Recommendation	Inquiry or review report in which the recommendation was made	Date the recommendation was accepted by the Government
Maternity safety and leadership	"There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay."	The Report of the Morecambe Bay Investigation, (March 2015)[9]	July 2015[10]
	"A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it."	The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013)[11]	November 2013[12]
Training of staff in health and social care	"Targeted interventions on collaborative leadership and organisational values, including a new, national entry-level induction for all who join health and social care."	The Health and Social Care Review: Leadership for a collaborative and inclusive future report (June 2022)[13]	June 2022[14]

9 Morecambe Bay Investigation: Report (March 2015)
10 DHSC, Learning not blaming: response to 3 reports on patient safety (July 2015)
11 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry , (February 2013)
12 Department of Health, Mid Staffordshire NHS FT public inquiry: government response, November 2013
13 Independent Report - Health and social care review: leadership for a collaborative and inclusive future (June 2022)
14 Independent Report - Health and social care review: leadership for a collaborative and inclusive future (June 2022)

Culture of safety and whistleblowing	"Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns. Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis. Action 1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led."	The Freedom to Speak Up Review (February 2015)[15]	July 2015[16]
	"Primary Care: All principles in this report should apply with necessary adaptations in primary care. Action 19.1: NHS England should include in its contractual terms for general/primary medical services standards for empowering and protecting staff to enable them to raise concerns freely, consistent with these Principles. Action 19.2: NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with this report. Action 19.3: In regulating registered primary care services CQC should have regard to these Principles and the extent to which services comply with them."	The Freedom to Speak Up Review (February 2015)[17]	July 2015[18]

The Committee approved the questions to guide our evaluation in respect of the five recommendations. We developed a set of sub-questions relating to specific areas of the recommendation. These main questions and sub-questions were incorporated into a final framework referred to as the Expert Panel's planning grid.

15 Freedom to Speak Up Review Report (February 2015)
16 DHSC, Learning not blaming: response to 3 reports on patient safety (July 2015)
17 Freedom to Speak Up Review Report (February 2015)
18 DHSC, Learning not blaming: response to 3 reports on patient safety (July 2015)

The main questions set out in the planning grid are:

- Has the recommendation been implemented? Or, (in the case of a recommendation deadline not yet reached) is the recommendation on track to be implemented?
- Has there been specific and adequate funding to enable the recommendation to be implemented?
- Has there been a positive impact on patients and people in receipt of social care as a result of the recommendation being implemented?
- Was the Government's interpretation and implementation of the recommendation appropriate?[19]

The approach of our evaluation was not a formal technical evaluation of the impact of different recommendations and should not be viewed as a substitute for Government commissioned evaluations via the National Institute for Health and Care Research (NIHR). We shared the planning grid with the Department, inviting them to respond to all main questions and sub-questions in its formal written response. We identified key stakeholders and invited them to submit their own written response to the planning grid. We invited health and care professionals, experts who had been involved in running public inquiries or reviews, patients, researchers, people in receipt of social care and advocates, to roundtable events, using discussion prompts informed by the planning grid.

We used the Department's response, its follow-up response and a supplementary response from NHSE, key questions in the planning grid, as well as our own thematic analysis of 26 written submissions, publicly available data, and transcripts from roundtable events with 16 participants as the basis for this evaluation.

Responses were analysed using a framework method for qualitative analysis in health policy research.[20] The integration process of all quantitative and qualitative evidence was based on Pawson's 'realist synthesis' framework of evaluating policy implementation in healthcare settings.[21]

Overall rating across all recommendations

The overall rating across all recommendations is 'requires improvement'. The ratings for the five commitments across the three policy areas and main questions were used to inform our overall rating for the implementation of recommendations in the area of patient safety. The ratings for each of the five recommendations in the three policy areas are summarised in the following tables.

19 Based on the questions as set out in the First Special Report of Session 2019–21: Process for independent evaluation of progress on Government commitments (July 2020), p. 3

20 Gale, N.K., Heath, G., Cameron, E., Rashid, S., and Redwood, S. "Using the framework method for the analysis of qualitative data in multi-disciplinary health research", BMC Medical Research Methodology, vol 13 (2013) pp. 1–8

21 Pawson R. 'Evidence-based Policy: The Promise of `Realist Synthesis'' . Evaluation, vol 8(3), (2002) pp. 340–358; Pawson, R., Greenhalgh, T., Harvey, G., and Walshe, K. "Realist review—a new method of systematic review designed for complex policy interventions" . Journal of Health Services Research and Policy, vol 10 (2005) pp. 21–34

Maternity care and leadership

Accepted Recommendation	A. Met	B. Funding and resource	C. Impact	D. Appropriateness	Overall
"There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. [...] Legislative preparations have already been made to implement a system based on medical examiners. [...] We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay." (From the Report of the Morecambe Bay Investigation, 2015)	Requires improvement	Requires improvement	Good	Good	Good
"A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it." (From the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013)	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement

Training of staff in health and social care

Accepted Recommendation	A. Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
"Targeted interventions on collaborative leadership and organisational values, including a new, national entry-level induction for all who join health and social care." (From the Health and Social Care Review: Leadership for a collaborative and inclusive future report, 2022)	Requires improvement	Inadequate	Requires improvement	Good	Requires improvement

Culture of safety and whistleblowing

Accepted Recommendation	A. Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
"Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns. Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis. Action 1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led." (From the Freedom to Speak Up Review, 2015)	Requires improvement	Good	Requires improvement	Good	Requires improvement
"Primary Care: All principles in this report should apply with necessary adaptations in primary care. Action 19.1: NHS England should include in its contractual terms for general/ primary medical services standards for empowering and protecting staff to enable them to raise concerns freely, consistent with these Principles. Action 19.2: NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with this report. Action 19.3: In regulating registered primary care services CQC should have regard to these Principles and the extent to which services comply with them." (From the Freedom to Speak Up Review, 2015)	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

The overall rating for the five recommendations across the three policy areas evaluated is: Requires improvement

This rating relates to the Government's progress overall against the five recommendations across the three policy areas based on guidance outlined in the anchor statements (Annex A) set out by the Committee.

We chose three policy areas to evaluate:

- Maternity and leadership;
- Training for health and social care staff;
- Culture of safety.

The five specific recommendations under these areas were chosen from a long list of recommendations which the Department identified as accepted by the Government. From the list the Department provided, we selected the following five recommendations to get an overview of the progress in improving:

- maternity safety,
- accountability of those in leadership positions,
- training and induction programmes in health and social care, and
- a culture of safety in which healthcare professionals feel safe to speak out when mistakes are made or when something concerns them.

Since 2013, when the first of the recommendations we have evaluated was made in the report on the Mid-Staffordshire NHS Foundation Trust,[22] several major public inquiries and reviews into substantive patient safety issues have identified related patient safety issues with maternity care, organisational culture and leadership.[23] Whilst our selected recommendations reflect this, we do not seek to cover these issues in their entirety.

We have factored in when the recommendation was made and accepted, in considering the progress of implementation. When we made our judgements regarding ratings, we also considered the fact that the Government is implementing recommendations made by independent bodies, which may pose different challenges compared to implementing policies the Government has developed itself. As part of our evaluation, we have therefore sought evidence about the appropriateness of the Government's interpretation and implementation of the recommendations, partly to enable us to provide feedback on this to the Government.

Overall, despite good performance in some areas, the evidence we received has led us to rate the Government's overall progress in the area of patient safety as 'requires improvement'. Our rating partly reflects the length of time it has taken for the Government to make progress on fully implementing four of the recommendations which were accepted nine

22 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry , (February 2013)

23 For example: DHSC, Final report of the Ockenden review , March 2022; DHSC, Maternity and neonatal services in East Kent: 'Reading the signals' report October 2022; The Lampard Inquiry " The Lampard Inquiry - investigating mental health deaths in Essex " accessed 7 November 2023

years ago, or longer. Progress is imminent in several areas, which is reassuring, but we remain concerned about the time it has taken for real action to be taken. In two cases, the promised guidance or legislation to implement the recommendation has been delayed.

In the area of maternity and leadership, we chose to look at a recommendation challenging the lack of independent oversight of perinatal deaths. Connected to this recommendation is the extension of the powers of medical examiners. We rated the implementation of the recommendation as 'good'. We acknowledge that implementation has taken nine years and, in fact, at the time of writing, it is still not fully implemented. However, on balance, we are encouraged by the progress regarding this recommendation.

The other four recommendations in the areas of leadership, training and establishing a culture of safety we rated as 'requires improvement'. The recommendations were to:

- Establish and enforce an effective common code of ethics, standards and conduct for senior board-level healthcare leaders and managers.
- Introduce targeted interventions on collaborative leadership and organisational values, and new entry-level induction for all staff joining health and social care.
- Create a culture of safety for all organisations providing NHS healthcare, with a specific emphasis on boards creating a safe environment where staff feel able to speak up, and effectively monitor progress.
- Ensure all staff working in primary care similarly feel safe to speak up and highlight poor practice, and that appropriate processes are in place for staff to raise concerns.

Regarding the implementation of a code of conduct for leaders, we saw evidence of guidance and good practice in some areas. In February 2024 NHSE published a Leadership Competency Framework for Board Members, which represents a significant step forward in helping to clarify what good practice looks like for board members. However, gaps in oversight and enforcement continue to cause stakeholders' concern. We therefore rated this as 'requires improvement'.

In the area of training of health and social care staff, we chose to evaluate a recommendation that aims to ensure staff across health and social care receive standardised training on organisational values and collaborative leadership. This in turn supports the changes to health and care delivery introduced under the Health and Care Act 2022. Despite encouraging developments regarding training for entry-level staff in the NHS, and some progress in developing a national offer for leadership training, we remain concerned about the lack of a unified approach to ensuring staff in social care receive adequate onboarding and further development training. We also note the lack of additional funding and resourcing to allow staff to take up and benefit from training offers. This has also been identified as a significant barrier in our previous evaluations. We therefore rated the implementation of this recommendation as 'requires improvement'.

In the area of culture of safety and whistleblowing, we chose to evaluate two recommendations that aim to improve patient safety in NHS trusts as well as in primary care. The recommendations focus on ensuring staff feel safe to raise concerns, and that leaders take action to monitor patient safety incidents and learn from the results. We

found evidence of significant progress in implementing the recommendations including the establishment of a National Guardian's Office and Freedom to Speak Up (FTSU) guardians within organisations, as well as the publication of the NHSE Patient Safety Strategy in 2019. However, we remain concerned that nine years on from the Government accepting the recommendations, implementation is not yet rolled out across health organisations, particularly within primary care. As such, we rated the implementation of both recommendations within this area as 'requires improvement'.

Our overall rating of 'requires improvement' for the Government's implementation of patient safety recommendations made by independent inquiries and reviews which it has accepted, reflects findings of some other reports. These reports often conclude that the recommendations from inquiries are not always fully implemented even though they have been accepted by the Government.[24] This discrepancy between a recommendation being accepted and being practically implemented has been termed "the implementation gap" by the Patient Safety Learning campaign.[25] In their report on the implementation of patient safety recommendations from independent inquiries, the Patient Safety Learning campaign identified one of the potential reasons for the implementation gap as lack of a mechanism to "assess how many of the same recommendations are being made [across multiple inquiries] and whether there is a systematic approach in place to implement recommendations."[26]

We want to acknowledge in our report, the continued impact of the Covid-19 pandemic which continues to present exceptional challenges for professionals working in all areas of health and social care, and which have in some cases delayed the implementation of recommendations. We want to express our gratitude for the huge efforts made by a range of staff working across the health and social care sectors who continue to work tirelessly under extremely difficult circumstances.

The rationale to support the rating and our findings for each of the selected recommendations is summarised below.

24 Institute for Government, How public inquiries can lead to change (December 2017); National Audit Office, Session 2017–2019, Investigation into government-funded inquiries, HC 836 23

25 Patient safety learning, Mind the implementation gap: The persistence of avoidable harm in the NHS (April 2022)

26 Patient safety learning, Mind the implementation gap: The persistence of avoidable harm in the NHS (April 2022)

Maternity Safety and Leadership

Accepted Government recommendation under evaluation:
"There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay." (From the Report of the Morecambe Bay Investigation, 2015) (Good)

- We found that parts of the recommendation are on track to be met. A system of medical examiners is in place and is due to be put on a statutory footing in April 2024, nine years on from when the recommendation was made and accepted. This will mean all deaths are independently scrutinised. However, the Government is yet to publish its decision about whether to include stillbirths within the remit of medical examiners, following a consultation which closed in 2019.

- There was some uncertainty amongst stakeholders regarding the adequacy of funding for the medical examiner system, and whether it would divert resource away from other parts of care provision.

- Some stakeholders criticised the availability of data on perinatal deaths, suggesting that more timely data would be useful to increase transparency. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK), commissioned to publish this data, struggles to receive timely and complete data from trusts which in turn delay their publications.

- Stakeholders were however generally positive regarding the impact of the recommendation, and many were positive about the prospective statutory scheme for medical examiners.

- On balance therefore we judge that the Government's progress towards implementing this recommendation was 'good'.

Accepted Government recommendation under evaluation:
"A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it." (Requires improvement)

- The general principles of common codes for ethics, standards and conduct exists in different pieces of guidance and frameworks. The Leadership Competency Framework for Board Members was published a few weeks before this report. We welcome this development, and stakeholders were generally positive about the aspirations of a common code. However, there are gaps in implementation, particularly around enforcement and investment in training.

- Regarding the appropriateness of the way the recommendation has been interpreted and implemented by Government, we heard concerns expressed by stakeholders about the lack of regulation of board members who are not members of a regulated healthcare profession and therefore not subject to the same professional requirements and sanctions as board members who are.

- Given the evidence we have seen, we have rated the implementation of this recommendation as 'requires improvement'.

Training of staff in health and social care

Accepted Government recommendation under evaluation: "Targeted interventions on collaborative leadership and organisational values, including a new, national entry-level induction for all who join health and social care." (From the Health and social care review: leadership for a collaborative and inclusive future report, 2022) (Requires improvement)

- Online entry-level induction training and guidance materials for all health and social care staff have been developed and will be launched, with a short delay, in spring 2024. As such, this aspect of the recommendation is on track to be implemented. We also received evidence suggesting that approximately 60% of all NHS staff have completed Level 1 training on essentials for patient care, which includes aspects of patient safety. Social care staff are not included in this figure.

- We did not however find evidence of a robust plan for implementing the induction training within the social care sector. Given the additional challenges related to introducing unified training within a large and fragmented sector with significant staffing issues, we were not convinced that the recommendation will be properly implemented across all sectors of health and care.

- Nor did we receive sufficient evidence to reassure us about how the induction and leadership training introduced in response to the recommendation will be integrated with the wide variety of existing training being developed and delivered across different organisations and providers across health and social care.

- The implementation of the recommendation has not received specific funding, except for some additional funding provided to the national organisation Skills for Care to increase awareness of the induction training within the care sector. As we concluded in our previous report looking at commitments made regarding the health and social care workforce, the sector is facing the significant staffing challenges. This can create difficulties for staff taking up training and translating the benefits from such training to patients and people in receipt of care. We remain unconvinced that the approach to funding and resourcing the implementation of the recommendation is sufficient.

- Many stakeholders suggested that the Department and NHSE's work in response to the training is important and likely to deliver significant benefits if implemented appropriately.

Culture of safety and whistleblowing

Accepted Government recommendation under evaluation:
"Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.

Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis.

Action 1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led." (From the Freedom to Speak Up Review, 2015) (Requires improvement)

- The implementation of this recommendation is ongoing. Significant progress has been made regarding establishing a National Guardian's Office, promoting a network of FTSU guardians, and creating patient safety frameworks. It is now nine years since the Government accepted the recommendation and we have taken this into account in our rating.
- There is considerable variation between organisations and trust types in the level of funding for, and progress in the implementation of FTSU guardians. In addition, not all trusts had implemented the Patient Safety Incidence Response Framework (PSIRF) or the Learning from Patient Safety Events (LFPSE) system by the NHSE Autumn 2023 deadline. NHSE told us that 63% had implemented the PSIRF by February 2024, and this varied by trust type: for example only 53% of Mental Health trusts had implemented it by that date compared to 80% of Ambulance trusts. Only 70% of trusts had implemented the LFPSE by February 2024 and the Department estimated that 90% will have done of by the end of March 2024.
- Although evidence we received indicated that resource and support had been provided to implement this recommendation, we note concerns from some stakeholders that funding for implementing the recommendation comes from existing NHS organisational budgets. This suggests that funding allocations for FTSU needs to compete with other budgetary needs of the trust.
- We did not receive sufficient evidence to judge whether the implementation of the recommendation has had a positive impact on patients and people in receipt of social care. However, we did receive evidence that staff confidence to speak up is at a 5 year low, and the Department acknowledged that work is needed to achieve the goal of the recommendation.
- Stakeholders generally welcomed the efforts made by the Government to improve patient safety following the recommendation. There were however some indications that the Government's practical interpretation of the recommendation did not go far enough in addressing the very significant issues within health

and care organisations. These concerns were mainly due to insufficient funding, insufficient consideration of how the recommendations intersect with existing guidance and regulation, and an over-emphasis on issuing guidance without monitoring and evaluation of the impact of it.

Accepted Government recommendation under evaluation: "Primary Care: All principles in this report should apply with necessary adaptations in primary care.

Action 19.1: NHS England should include in its contractual terms for general/primary medical services standards for empowering and protecting staff to enable them to raise concerns freely, consistent with these Principles.

Action 19.2: NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with this report. Action 19.3: In regulating registered primary care services CQC should have regard to these Principles and the extent to which services comply with them." (From the Freedom to Speak Up Review, 2015) (Requires improvement)

- There has been some encouraging progress in facilitating a culture where people feel empowered and able to speak up in primary care. We received some evidence of Integrated Care Boards (ICBs) implementing processes to ensure staff in organisations across their systems, including primary care, were able to speak up.
- Specific guidance on the roll out of FTSU guidance in primary care has been delayed to 31 March 2024, despite the recommendation being made in 2015 and accepted by the Government in the same year.
- The evidence we received identified significant gaps in embedding patient safety learning within primary care, especially within dentistry and community pharmacy primary care sectors, and in very small organisations or teams. Recent staff surveys shows that primary care professionals are less likely than staff in NHS trusts to engage with a FTSU guardian or another internal route to raise concerns.
- Within primary care, there was an initial allocation of funding for the National Guardian's Office to explore the roll out of FTSU actions. There has not been any additional funding to support the roll out and to address the particular challenges around speaking up routes, and to ensure access to guardians. However, given that FTSU guardians are in place within some areas of primary care, we conclude that funding and resource provisions are not a major barrier to implementation.

A full list of the written evidence we received is included at the end of the report (see Annex B).

Evidence from the Department

- Additional written information received from the Department and NHSE.

Evidence from stakeholders:

- 26 written submissions.

Roundtable events

- Roundtable events with 16 participants with experience of patient safety. This included health and social care professionals, patients or people in receipt of social care and advocates for patients and people in receipt of social care. The roundtable also included a group of professionals who had themselves led or been involved in public inquiries or reviews which had made patient safety related recommendations. Members of this last group have agreed to be identified within our report. Where names of individuals have been given, those individuals have approved the use of their quotes.

This report provides an analysis of all information provided. The analysis is structured around the four overall policy areas which covered five individual recommendations, and the main questions (A-D) within each recommendation.

1 Maternity Care and Leadership

Accepted recommendation	A. Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
"There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay." (From the Report of the Morecambe Bay Investigation, 2015)	Requires improvement	Requires improvement	Good	Good	Good
"A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it." (From the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013.)	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement

In this section we provide an assessment of the Government's progress against implementing two recommendations in relation to maternity care and leadership. These recommendations were selected for evaluation:

"There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay." (From the Morecambe Bay Investigation report, 2015)

"A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it." (From the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013)

The first recommendation in this chapter is focused on maternity care. It comes from the 2015 report of the Morecambe Bay Investigation, which was a non-statutory review into serious failures of maternity and neonatal clinical care at the Furness General Hospital, part of what became the University Hospitals of Morecambe Bay NHS Foundation Trust. The review was established by the Secretary of State of Health in 2013 and was chaired by Dr Bill Kirkup CBE.[27] The review's report found that the hospital did not always investigate maternal deaths appropriately. It recommended that a system based on medical examiners should be introduced, as this would provide a systematic national mechanism to scrutinise patterns in perinatal and maternal deaths and a process through which early warning signs of potential problems in care could be picked up.[28]

Independent scrutiny of perinatal deaths and maternal deaths is one of a number of measures relating to the Government's commitment to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries in babies occurring soon, or after, birth by 2025.[29] According to a House of Commons library briefing on investigations into stillbirths, the term "perinatal mortality" refers to a foetus who has died from the 24th week of pregnancy and includes child deaths up to the first week of life.[30] Perinatal deaths include stillbirths, defined under Section 41 of the Births and Deaths Registration Act 1953 (as amended), as:

> *"[…] a child which has which has issued forth from its mother after the twenty-fourth week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life, and the expression "still–birth" shall be construed accordingly; […]"*[31]

In our previous evaluation of maternity services, we acknowledged the challenges in defining perinatal deaths, noting in particular a change in the management of extreme preterm births at under 27 weeks' gestation, which resulted in more pre-term births being

27 Morecambe Bay Investigation: Report (March 2015)
28 Morecambe Bay Investigation: Report (March 2015)
29 DHSC, Safer Maternity Care: The National Maternity Safety Strategy – Progress and Next Steps (November 2017)
30 House of Commons Library, Investigation of stillbirths, Research briefing CBP-8167 (October 2023)
31 Births and Deaths Registration Act 1953, section 41

classified as live births when they previously may have been classified as late foetal losses, and which led to a change in the Department's definition of neonatal deaths to include only babies born at 24 weeks' gestation or longer.[32]

Coroners usually investigate deaths which are "violent or unnatural", "unknown" or have taken place in state detention. When a death is reported to a coroner, they may decide that a post-mortem and/or an inquest is required.[33] Coroners do not however currently have jurisdiction to investigate stillbirths. This is because the coroner's remit to investigate only extends to deaths where there has been "independent life".[34] In February 2023 Chief Coroner, HHJ Thomas Teague KC published guidance on 'Stillbirth, and Live Birth Following Termination of Pregnancy' (updated in February 2024), which sets out that "as where there has not been an independent life, there has not legally been a death". The guidance also stipulates that where there is uncertainty as to whether the child was born alive, the coroner may investigate in order to determine whether this was the case.[35] In England, cases where the baby was thought to be alive at the start of labour and then born without signs of life, are investigated by the Maternity and Newborn Safety Investigations (MNSI) programme, which since October 2023 has been hosted by the CQC.[36]

Medical examiners are senior medical doctors who provide independent scrutiny of the causes of deaths that are outside the coroner's remit called "non-coronial deaths".[37] The system of medical examiners is one of several mechanisms in England to provide scrutiny of perinatal and maternal deaths and to warn of adverse trends. According to NHSE, the purpose of the medical examiner system is to:

> *"- provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths*
>
> *- ensure the appropriate direction of deaths to the coroner*
>
> *- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased*
>
> *- improve the quality of death certification*
>
> *- improve the quality of mortality data."*[38]

In April 2023 Minister Maria Caulfield MP told the House of Commons in a written Ministerial statement, that medical examiners would be put on a statutory footing from April 2024:

> *"The changes will put all of the medical examiner system's obligations, duties and responsibilities on to a statutory footing and ensure they are recognised by law. For example, it will be a legal requirement that medical examiners*

32 The Health and Social Care Committee, The Health and Social Care Committee's Expert Panel: Evaluation of Government commitments in the area of maternity services in England HC 18 (July 2021)
33 Courts and Tribunals Judiciary, 'Coroners', accessed 24 February 2024
34 House of Commons Library, Investigation of stillbirths, Research briefing CBP-8167 (October 2023)
35 Chief Coroner's Guidance No.45 Stillbirth, and Live Birth Following Termination of Pregnancy (updated February 2024)'
36 Maternity and Newborn Safety Investigations, 'HSIB Legacy', accessed 5 December 2023
37 NHSE, 'The national medical examiner system', accessed 4 March 2024
38 NHSE, 'The national medical examiner system', accessed 4 March 2024

> *scrutinise all non-coronial deaths. This will help to deter criminal activity and poor practice, increase transparency and offer the bereaved an opportunity to raise concerns.*
>
> *[…] The introduction of medical examiners is part of a broader death certification, registration and coronial process. We are working closely across Government to ensure that from both a legislative and operational perspective we are supporting the professions involved so that they are prepared for the full introduction of the statutory system from April 2024."*[39]

In December 2023 the Government published guidance regarding changes to the death certificate procedure, and the introduction of medical examiners. Along with this guidance the Government published draft legislation which it welcomed comments on. The Government set out the following timetable:

> *"Between January and April 2024:*
>
> *- final regulations will be laid in Parliament and the Senedd with a coming-into-force date from April 2024. The regulations that will be made are summarised in Annex A*
>
> *- face-to-face training for medical examiners and medical examiner officers will be provided by the Royal College of Pathologists and online training provided by NHS England*
>
> *- existing guidance, including guidance from the national medical examiner's office and office of the chief coroner, will be updated to reflect the statutory changes*
>
> *- the new MCCD [medical certificate of cause of death] will be made available in preparation for use."*[40]

In 2015 the Morecambe Bay review recommended that the systematic review of deaths by medical examiners be extended to stillbirths as well as neonatal deaths.[41] This was accepted "in principle" by the Department in their response to the report, published July 2015. The Department indicated the medical examiners system had been successfully trialled and that further progress would be informed by a review of the pilots and a public consultation. However, despite accepting the recommendation in principle, in its response the Department also stated that medical examiners would not examine stillbirths for legal reasons, and stated that MBRRACE-UK (which monitors maternal and perinatal deaths, see below for details) was sufficient to "learn national lessons for improvement of care":

> *"Medical examiners would scrutinise all deaths except for stillbirths (for legal reasons) and any death that requires a coroner investigation. However,*

39 HC Deb 27 April 2024, UIN HCWS750 [Commons written ministerial statement]

40 DHSC, 'An overview of the death certification reforms', updated 14 December 2023

41 The second recommendation accepted by the Government was: "Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer."

> *the MBRRACE confidential enquiries provide independent scrutiny of all maternal deaths and topics related to stillbirths and neonatal deaths, which is sufficient to learn national lessons for improvement of care."*[42]

The MBRRACE-UK collaboration has monitored maternal deaths, stillbirths and infant deaths in the UK since its establishment in 2013. MBRRACE-UK is jointly commissioned by the Department and the Welsh and Scottish Governments and based at the University of Oxford in collaboration with the University of Leicester.[43] In their submission MBRRACE-UK explained their role as follows:

> *"[MBRRACE-UK] investigates the care of all women who die during pregnancy and up to one year after the end of pregnancy, and selected cases of severe maternal morbidity during or after pregnancy in the UK through routine surveillance and confidential enquiries. The [MBRRACE-UK] collaboration also undertakes surveillance of all stillbirths, late fetal losses and neonatal deaths (deaths up to 28 days of age) in the UK, alongside confidential enquiries into the care of specific samples of babies who die or have serious morbidities. Confidential enquiries are national, independent investigations into the circumstances around each death and the care received prior to each death."*[44]

MBRRACE-UK also delivers the Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP), which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths. As part of this programme, MBRRACE-UK publishes an annual perinatal mortality surveillance report, which identifies risk factors, causes and trends, and makes recommendations on how stillbirth rates can be reduced.[45]

MBBRACE-UK was instructed to develop a standard Perinatal Mortality Review Tool (PRMT). The PRMT is described in the Government guidance document 'Child Death Review Statutory and Operational Guidance (England)' as a "web-based tool which supports standardised, systematic review of care in perinatal deaths". This guidance document also sets out the process following the death of a child, with the formal process of investigation starting with a so-called "Child Death Review Meeting" (CDRM). This meeting involves all professionals directly involved in the care at the time of death. If the child died in the neonatal intensive care unit, the review group meeting is supported by the PMRT.[46]

A House of Commons briefing on investigation of stillbirths states that reviews by the hospital which provided the care at the time of death are different from a coroner's investigation or inquest, and that for about 90% of parents the PMRT review process is likely to be the only hospital review of their child's death that will take place.[47]

The second recommendation in this policy area is from the Mid Staffordshire NHS Foundation Trust Public Inquiry, which was led by Sir Robert Francis KC and was

42 DHSC, Learning not blaming: response to 3 reports on patient safety (July 2015)
43 University of Oxford, 'MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK', accessed 5 December 2023
44 MBRACE-UK (PSN0002)
45 House of Commons Library, Investigation of stillbirths, Research briefing CBP-8167 (October 2023)
46 HM Government, Child Death Review Statutory and Operational Guidance (England), September 2018
47 House of Commons Library, Investigation of stillbirths, Research briefing CBP-8167 (October 2023)

published in 2013. This statutory public inquiry looked into the failure of care at the Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The full recommendation set out that:

> *"A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and should be consistent with the common culture. The principles appearing in those ethics and standards should apply to all staff, and it is the responsibility of employers to ensure that they are honoured. Serious non-compliance with the code should be grounds for considering a leader not a fit and proper person to be a director. An alternative would be to set up a professional regulator, the need for which could be better assessed after reviewing experience with the "fit and proper person" requirements."*[48]

The "fit and proper persons requirement" referred to in the recommendation was set out in regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These regulations delegate the power to assess whether executive and non-executive directors are fit to carry out their role (this does not extend to foundation trust governors) to the CQC. The CQC is also given the power to assess whether the provider has ensured measures are in place to determine whether directors are fit and proper persons.[49] An NHS Providers briefing on how to comply with these regulations summarises it as:

> *"Providers must not appoint a person to an executive director level post (including associate directors) or to a non-executive director post unless they are:*
>
> - *Of good character;*
> - *Have the necessary qualifications, skills and experience;*
> - *Are able to perform the work that they are employed for after reasonable adjustments are made;*
> - *Can supply information as set out in Schedule 3 of the Regulations.*
>
> *Paragraph 5 (4) of regulations states that in assessing whether a person is of good character, the matters considered must include those listed in Part 2 of Schedule 4.' Part 2 of Schedule 4 refers to:*
>
> - *Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and*
> - *Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals."*[50]

48 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013)
49 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 5
50 NHS Providers, Briefing: Complying With The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (March 2015)

Recommendation: Implement national medical examiners to scrutinise maternal and perinatal deaths independently (accepted by the Government in 2015)

Overall Recommendation Rating and Overview: Good

This recommendation highlighted difficulties in scrutinising perinatal deaths and maternal deaths independently. Independent scrutiny, the recommendation suggests, would help to identify patient safety concerns and better identify early warning of "adverse trends". The recommendation was made, and subsequently accepted by the Government, in 2015.[51] In the intervening time since, the Government has overseen the introduction and creation of various mechanisms for independent scrutiny, which are all outlined in the sections below along with stakeholder commentary on progress.

In their evidence, the Department stated that they had established in September 2023 the Maternity and Neonatal National Oversight Group, chaired by Minister Maria Caulfield, to oversee the implementation of national level recommendations made by several independent maternity reviews.[52] While we have not evaluated the effectiveness of this group, we are encouraged by the attempt to bring together and implement recommendations from multiple independent reviews within the same policy area.

Overall, we agree that the Government's progress regarding the implementation of this recommendation has been 'good'. There are however some areas that require improvement. The extended remit for medical examiners to scrutinise perinatal and maternal deaths is not in place. There was also some uncertainty amongst stakeholders regarding funding arrangements. Additionally, there are concerns about the ways in which the various mechanisms to scrutinise deaths merge to effectively warn of trends. The below section sets out our full analysis.

Was the recommendation implemented (or on track)? Rating: Requires improvement

This recommendation suggests that the system of independent scrutiny of perinatal and maternal deaths should be based on a system of medical examiners. In response to our question on whether the recommendation had been, or was in the process of being implemented, many submissions pointed to a range of processes utilised to scrutinise perinatal and maternal deaths, including:

- Medical examiners,
- MBRRACE-UK and the Perinatal Mortality Review Tool (PMRT),
- the Maternity and Newborn Safety Investigations (MNSI) programme, and
- coronial investigations.[53]

51 DHSC, Learning not blaming: response to 3 reports on patient safety (July 2015)

52 Department of Health and Social Care (PSN0027)

53 NHS Norfolk and Waveney ICB (PSN0009); NHS North Central London ICB (PSN0014); NHS Cornwall and Isles of Scilly ICB (PSN0017); NHS Gloucestershire ICB (PSN0020)

Some NHS organisations also referred to their own internal reporting systems, and investigations at Board and ICB level. For example, NHS Norfolk and Waveney ICB stated that:

> *"All maternity-related deaths are reviewed by the Local Maternity and Neonatal System (LMNS) panel made up of the LMNS Team and our three local acute trusts. All deaths are also reported to the LMNS Board."*[54]

NHS Cornwall and Isles of Scilly ICB welcomed the MNSI programme, stating:

> *"Our maternity services have welcomed the MNSI investigations and collaborated openly. considerable improvements have been made because of this."*[55]

NHS North Central London ICB stated that all incidents of perinatal death are reported as Serious incidents (SIs) and are captured a Perinatal Surveillance Quality tool. This is then reported internally to a "quality committee and Board" and subsequently reported to the ICB through a "monthly Perinatal Quality Surveillance group". NHS North Central London ICB further stated that in one of their trusts:

> *"All learning from SIs is shared with teams and at monthly departmental briefings and maternity learning bulletin. Attendance for monthly briefings is mandated for all clinical and governance maternity staff. [Our trust's] perinatal review process is well developed with monthly Perinatal dashboard reported to Quality Committee and active mechanism of escalation to Board in place."*[56]

The submissions that specifically referred to the medical examiner system indicated that such a system is in place.[57] NHS Gloucestershire ICB concluded that the introduction of the medical examiner programme was a "critical development" in the scrutiny of perinatal and maternal deaths, and that their ICB was acting as a trial site for the national programme, and that locally, their medical examiner programme is "now gathering pace to roll out into primary care as part of the death certification reforms".[58]

The Midlands Patient Safety Research Centre stated that the medical examiners system alongside MBRRACE-UK facilitates data collection of maternal and perinatal deaths (including stillbirth). However, they argued that "the latter is relatively poorly captured by existing systems" which they concluded "undermines its utility".[59]

NHS Frimley ICB agreed that some progress had been made towards implementing the recommendation, but suggested that although existing programmes such as MBRRACE-UK provide the ability to detect trends and analysing cases at a both local and national levels the challenge is to "independently scrutinising trends in real time" as MBRRACE-UK reports publish data from two preceding years.[60] Royal College of Obstetricians and

54 NHS Norfolk and Waveney ICB (PSN0009)
55 NHS Cornwall and Isles of Scilly ICB (PSN0017)
56 NHS North Central London ICB (PSN0014)
57 The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (PSN0024); The Royal College of Pathologists (PSN0005); The Midlands Patient Safety Research Centre (PSN0010); The Medical Protection Society (PSN0013); The Royal College of Physicians of Edinburgh (PNS0011)
58 NHS Gloucestershire ICB (PSN0020)
59 The Midlands Patient Safety Research Centre (PSN0010)
60 NHS Frimley ICB (PSN0015)

Gynaecologists (RCOG) and the Royal College of Midwives (RCM) submission similarly highlighted that data risked being out of date and suggested that it would be "beneficial for the whole system if data could be provided in a timelier way". RCOG and RCM also expressed concern that "not all units comply with reporting requirements for PMRT".[61]

Sands and Tommy's Joint Policy Unit reported concerns that the PMRT within NHS Trusts is not always effective due to lack of independence and insufficient data quality:

> *"[…] there is limited external oversight and accountability of reviews led by hospitals where deaths occurred. Quality of the review is influenced by the availability of relevant information"*[62]

Sands and Tommy's Joint Policy Unit pointed to a review of PMRT carried out by MBRRACE-UK as part of their review of confidential inquiries into Black and Asian baby deaths, which found that many PMRT reviews were carried out by one doctor or midwife instead of a group of professionals, or by a group which was too small not covering the key specialisms needed.[63] A participant during our roundtable similarly expressed concerns regarding the specialist knowledge needed to provide the right data to the independent review mechanisms:

> *"So gathering the evidence for those for scrutiny, are all offices comfortable that we've got and processes in place? I think the answer is no, but we're all working on it. Do all the teams have the necessary expertise to understand maternal medicine? Not sure about that, particularly in small teams. Now I happen to have done 20 years of mat[ernal] med[icine] so for our team it's pretty straightforward, but that makes me quite unusual. I think there is that expertise gap."*[64]

According to RCOG and RCM, what they identified as a "last-minute" decision in 2023 to host the MNSI within the Care Quality Commission (CQC), meant that:

> *"[…] questions remain over the independence of the Maternity and Newborn Safety Investigations (MNSI) programme … . Staff in maternity services have raised concerns about this hosting arrangement and it is not clear what measures are in place to ensure MNSI work is fully independent from the related work of the CQC."*[65]

RCOG and RCM further added that:

> *"Recent reports have highlighted problems with Board-level scrutiny of maternity services, with the response of Boards and senior managers to avoid taking responsibility for their organisation's performance and generally falling short of the standards that could reasonably be expected of them."*[66]

In December 2023, Minister Maria Caulfield provided an update to the House of Commons regarding the Government's plan to reform the medical examiner system and

61 The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (PSN0024)
62 Sands and Tommy's Joint Policy Unit (PSN0023)
63 Sands and Tommy's Joint Policy Unit (PSN0023)
64 Expert Panel roundtable - Group 1
65 The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (PSN0024)
66 The Royal College of Obstetricians and the Gynaecologists and Royal College of Midwives (PSN0024)

death certification. In the statement, Minister Caulfield set out that such reforms would legally place all deaths under investigation by the medical examiner or a coroner, and that the Government was working to ensure that "appropriate operational processes are in place to deliver these changes from April 2024".[67]

During our roundtable, one of the participants, a medical examiner, pointed to the delays in rolling out the extension of medical examiner remit, and questioned whether it would be effective from April 2024:

> *"There have been hold-ups to it being rolled out. The pandemic massively delayed things as you can probably imagine. So I think there was a plan that actually in 2021 the system was going to be going statutory, but that was delayed with the pandemic. There was then - what felt to us as lead medical examiners - a fairly definite plan that it was going to become statutory in April 2023. But in the months running up to that, it became apparent that that was going to be delayed for a number of reasons. The rollout hadn't gone as quickly as people had expected, the IT support behind it is not there, is probably the best way to describe it. So difficulty getting organisations on board with referring in all of the patients that had died, and then accessing notes. The Department of Health was wanting to have an electronic medical certificate in place which still being designed and also a database so that medical examiners will be able to upload information. And I think the hope is that that database would be able to give more information about trends and themes. But that is sort of still awaited. The current plan is that all deaths will be reviewed from April 2024, but as I've learned doing this role, "from" has a definition of "at some time in the future". So there is still no definite date for it becoming statutory. But we are advised that that will be happening in the near future. We will be told when that's going to happen."*[68]

In another roundtable group the President of the Royal College of Pathologists (RC Path) Dr Bernie Croal indicated that there had been delays in implementing the medical examiner system even prior to the pandemic, and these were, at least in part, due to lack of funding from the Department:

> *"Certainly RCPath began discussions with Government from 2013-14 onwards, and Dr Suzy Lishman, who then became President [of RCPath] just around that time, was very instrumental in pushing that. The block was with the Health Secretary at the time who didn't provide the funding to enable RCPath to develop and facilitate the training. The funding didn't come until later on - 2019. Since then, we've trained over 2000 medical examiners with more are coming through the system."*[69]

The Government's submission referenced mechanisms to independently scrutinise perinatal and maternal deaths, including the PMRT, the MNSI and the NHS Perinatal Quality Surveillance Model (PQSM). The submission also referenced the 2019 consultation on coronial investigations of stillbirths and stated that:

67 HC Deb, 14 December 2023, Statement UIN HCWS131 [Commons written ministerial statement]
68 Expert Panel roundtable – Group 1
69 Expert Panel roundtable – Group 2

> *"The landscape of maternity investigations has changed significantly since the consultation; as outlined above, the Maternity and Newborn Safety Investigations programme is now in place, and the Perinatal Mortality Review Tool supports standardised perinatal mortality reviews across NHS maternity and neonatal units in the UK. Additionally, DHSC officials are working to improve the information available to families regarding these investigative processes that may be taken forward following a stillbirth."*[70]

Although we recognise that there are now several more mechanisms in place to facilitate independent scrutiny of perinatal and maternal deaths, we do not agree that this recommendation has been fully met. We are aware that further changes to the remit of medical examiners are imminent, but in addition to points made above about readiness of the necessary infrastructure, possible gaps in relation to stillbirths, and the timeliness of data collection, it has taken the Government nine years to implement this recommendation from the point at which they accepted it. Therefore, in respect of whether the recommendation has been, or is in the progress of being implemented, we conclude that it requires improvement.

Was the recommendation effectively funded (or resourced)? Rating: Requires improvement

The submissions addressing this recommendation largely focused on the funding available for the suite of scrutiny mechanisms. With regards to the funding of this recommendation, the Government's submission focused only on the medical examiner system. The submission stated that:

> *"Yes, the Medical Examiner system is centrally funded in England and Wales and this will continue to be the way the statutory Medical Examiners system will be funded. Costs are detailed in a combined impact assessment for the Health and Care Act 2022."*[71]

During our roundtable one of the participants working in healthcare expressed uncertainty regarding funding for the extended medical examiner system, as different geographic areas would deal with a different workload:

> *"There is funding there that's come through NHS England for it. Whether that is going to be enough for the total number of deaths, because we don't know how many deaths that is. Because the way the statistics are done, we might be able to know what the number of deaths are for the country or the county or whatever, but it won't exactly tell us what the number of deaths are for our particular area, because the boundaries are different for County Council, they're different for coroners, they're different for the trust."*[72]

Some submissions called for additional funding for data collection and analysis. The Midlands Patient Safety Research Centre argued:

70 Department of Health and Social Care (PSN0027)
71 Department of Health and Social Care (PSN0027)
72 Expert Panel roundtable – Group 1

> *"[…] adequate funding and systems to enable Trusts to submit their data, and MBRRACE or appropriately approved researchers to analyse it, might maximise benefit."*[73]

Similarly, NHS Frimley ICB recommended that:

> *"[…] additional funding to provide MBRRACE data in real time or with a lag that is shorter than the current two years would dramatically improve the ability to independently analyse and scrutinise deaths and trends and pick up on early warnings."*[74]

According to NHS North East London ICB, funding to support their PMRT processes were only available for the financial year 2022/23 rather than over a longer term, which they characterised "insufficient".[75] They also cautioned that lack of staffing resource could impact on the ability to provide scrutiny alongside clinical care:

> *"[…] by providing external scrutiny there is a risk that workforce is taken away from clinical care, particularly when there are factors that impact on workforce numbers such as industrial action."*[76]

Several ICBs mentioned that they used Ockenden funding[77] for their maternity services. Speaking of their Perinatal Surveillance Quality tool, NHS North Central London ICB stated that:

> *"[…] there is no additional funding specifically for this, however there is funding through Ockenden actions for a number of related workstreams such as Equality and Equity."*[78]

NHS Cornwall and Isles of Scilly ICB stated that they had invested £804,000 of Ockenden funding into maternity, which they argued "is reflected in the positive reputation" of their services.[79] NHS Suffolk and North East Essex ICB noted that their funding for perinatal safety comes from a mix of ICB funding (£46.5m per annum), an annual non-recurring Service Development Fund from NHSE (£420,000 in 2023/24), and Ockenden funding (£1,378,000 in 2022/23 with an additional £376,203 in 2023/24). While the ICB acknowledged that the Ockenden funding was "significant", they "request that the funding levels be reviewed on a regular basis to ensure they are appropriate for the need."[80]

Although the medical examiner system will be funded when it is in place, doubts remain as to whether the funds will prove sufficient. We note that some evidence also suggested that funding issues contributed to the delay to putting medical examiners on a statutory basis.[81] There are also concerns as to the adequacy of funding of the wider scheme of

73 The Midlands Patient Safety Research Centre (PSN0010)
74 NHS Frimley ICB (PSN0015)
75 NHS North East London ICB (PSN0022)
76 NHS North East London ICB (PSN0022)
77 NHSE and NHS Improvement Board Meeting November 2021, 'Agenda Item 6: Maternity and Neonatal Services Update', accessed 27 February 2024
78 NHS North Central London ICB (PSN0014)
79 NHS Cornwall and Isles of Scilly ICB (PSN0017)
80 NHS Suffolk and North East Essex ICB (PSN0018)
81 Expert Panel roundtable - Group 2

measures designed to ensure independent scrutiny of maternal and perinatal deaths. We therefore conclude that progress in regard to funding for the implementation of this recommendation requires improvement.

Did the implementation of the recommendation achieve positive impacts for patients and people in receipt of social care? Rating: Good

Submissions focused on the impact of the wider scheme of scrutiny mechanisms rather than solely on medical examiners. Independent scrutiny of perinatal and maternal deaths often involves bereaved parents and families. Sands and Tommy's Joint Policy Unit stated:

> *"The PMRT has highlighted the continued need for greater parent engagement in reviews. There must be measures in place to ensure that parents are supported to genuinely engage in the review, including a formal way of challenging the PMRT report if they disagree with findings, with an appeals process. The PMRT's latest report suggests improvements in parents' engagement. 95% of reviews sought parents' perspectives in 2022–23, compared to 75% in 2018–19."*[82]

Overall, submissions were positive regarding the impact of these mechanisms. NHS Suffolk and North East Essex ICB reported that:

> *"[…] there is now greater patient involvement in investigative processes and reviews including PMRT, HSIB [i.e. MNSI] and PSIRF and this will have benefitted service users in terms of feeling listened to and being able to contribute to the learning response."*[83]

NHS North East London ICB concluded that "all service users have benefited" from the recommendation being accepted and implemented, highlighting the Independent Senior Advocate role that their ICB is piloting as a particular strength.[84] MBRRACE-UK cited findings from their own data which they argued are improving safety overall:

> *"[…] continue to demonstrate improvements to care which may have made a difference to the outcome of care for women and/or their babies."*[85]

NHS Cornwall and Isles of Scilly ICB submission highlighted areas which they had identified as improvements made through collaborating with MNSI investigations. These they stated, included:

> *"[…] innovations such as perinatal pelvic health services, maternal mental health services and the WREN team who provide enhanced continuity of care for vulnerable women."*[86]

82 Sands and Tommy's Joint Policy Unit (PSN0023)
83 NHS Suffolk and North East Essex ICB (PSN0018)
84 NHS North East London ICB (PSN0022)
85 MBRRACE-UK (PSN0002)
86 NHS Cornwall and Isles of Scilly ICB (PSN0017)

However, some submissions also highlighted that review processes could be upsetting for parents and families involved, especially if not conducted efficiently.[87] Sands and Tommy's Joint Policy Unit stated that:

> *"Sands research has found that while some parents describe a positive experience, others report poor communication, delays, and explanations about their baby's death which still leaves them with questions. 1 in 5 parents surveyed by Sands did not understand what the review entailed which limited their ability to engage in the process. 34% of parents said they did not receive answers, either because they were unaware of the review (11%) or because they took part in the review, but it did not provide any answers (23%)."*[88]

The Government submission set out that:

> *"The Medical examiners system gives bereaved people an opportunity to ask questions and raise concerns about care. It will also allow trends in deaths to be observed. Feedback from bereaved people has been overwhelmingly positive. Further information is available in the Medical Examiner National reports. Additional information on scrutiny of maternal and perinatal deaths is available in published reports from MBRRACE and MNSI."*[89]

We conclude that the impact of implementation of this recommendation is 'good', as many benefits have been highlighted within the evidence we looked at.

Was the recommendation interpreted appropriately? Rating: Good

Submissions largely agreed that the recommendation had been appropriately interpreted and implemented. NHS Norfolk and Waveney ICB stated that "the recommendation has ensured that all deaths have system scrutiny and oversight as intended."[90] NHS Suffolk and North East Sussex ICB concluded that:

> *"[…] the recommendation was reasonable and has resulted in further measures being implemented. The developments as described above are likely a consequence of the original recommendations."*[91]

Concerns were also raised as to the efficiency of data collection and use. The Midlands Patient Safety Research Centre argued that focus was needed on improving the current system, stating that "establishment of any new system would be less helpful than ensuring better data within MBRRACE."[92] Sands and Tommy's Joint Policy Unit also noted that "information from the PMRT does not feed into a wider national system for improving safety."[93]

The Government's submission argued that their implementation of the recommendation was appropriate, as "all deaths in England and Wales will be independent reviewed, without

87 NHS North East London ICB (PSN0022); The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (PSN0024)
88 Sands and Tommy's Joint Policy Unit (PSN0023)
89 Department of Health and Social Care (PSN0027)
90 NHS Norfolk and Waveney ICB (PSN0009)
91 NHS Suffolk and North East Essex ICB (PSN0018)
92 The Midlands Patient Safety Research Centre (PSN0010)
93 Sands and Tommy's Joint Policy Unit (PSN0023)

exception, either by a medical examiner or a coroner" once the regulations governing the medical examiner system comes into force. The Government also noted that, in addition to medical examiners, "the mechanisms for scrutiny of stillbirths described above provide the tools for independent review and surveillance."[94]

We conclude that the Government's interpretation of this recommendation into practical action is good.

Recommendation: A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers (accepted by the Government in 2013)

Overall Recommendation Rating and Overview: Requires improvement

This recommendation calls for a common code of ethics, standards and conduct for senior board-level healthcare leaders and managers. In the inquiry report setting out the recommendation, Sir Robert Francis KC, the inquiry chair, sets out:

> *"A nationally applied code of conduct, ethics and professional standards would have the advantage of protecting leaders from undue pressure from whatever source, whether their own board colleagues, governors, commissioners or others, in relation to matters such as the balance between saving costs and patient safety."*[95]

In their response to the inquiry report, the Government accepted the recommendation, and stated that a set of standards produced by the Professional Standards Authority (PSA) entitled 'Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England', "provide the basis for standards for senior board-level leaders and managers." The Government's response also stated that these standards would be one part of a wider "system" to ensure that senior people in the NHS are "fit and proper". The response also referred to:

- Guidance entitled 'The Healthy NHS Board 2013' to support board effectiveness and highlight "the importance of values and behaviours".
- CQC reports which would give an indication to whether an organisation was "well led".
- A consultation for a new "fitness test" for Board level directors (and equivalents).[96]

On 28 February 2024 NHSE published its Leadership Competency Framework for Board Members. The intention for the Framework is for it to be used in job descriptions and recruitment processes, and to be followed in autumn 2024 by a new Board Member Appraisal Framework. The Framework includes six domains in which leaders will need to demonstrate competency:

- driving high-quality and sustainable outcomes
- setting strategy and delivering long-term transformation

94 Department of Health and Social Care (PSN0027)
95 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry , February 2013
96 Department of Health, Hard Truths - The Journey to Putting Patients First (January 2014)

- promoting equality and inclusion, and reducing health and workforce inequalities
- providing robust governance and assurance
- creating a compassionate, just and positive culture, and
- building a trusted relationship with partners and communities.[97]

This Framework forms part of the Fit and Proper Persons Test (FPPT) framework and was developed as part of the Government response to the following recommendation from the Kark Review: 'the design of a set of specific core elements of competence, which all directors should be able to meet and against which they can be assessed'. The Kark review was commissioned by the Secretary of State for Health and Social Care and reported in 2019. The review was conducted by barristers Tom Kark KC and Jane Russell.[98]

The publication of the Framework is a significant step forward that will help clarify what good practice looks like for board members. Whilst there is an overlap with the recommendation we are evaluating to provide "a code of ethics, standards and conduct" for board members, the Framework describes competencies and doesn't specially include ethical judgements board members may need to make, for example in exercising their independent judgement to balance costs with patient safety.

Overall, the evidence we have seen indicates that there are useful guidelines and frameworks to draw upon in regard to conduct, ethics and standard for senior leaders within healthcare, however, there seems to be a disparity between what the Government states it has delivered and how it is perceived by some stakeholders. We conclude that there are some specific issues in terms of enforcement and lack of investment in training. We therefore conclude that progress towards meeting this recommendation requires improvement.

Was the recommendation implemented (or on track)? Rating: Requires improvement

In their response to our evaluation, the PSA were clear in their view that the recommendation had not been met, stating:

> *"It is our understanding that recommendation 215 has not been fully implemented, despite several attempts to address a standards and accountability gap relating to NHS managers."*[99]

Furthermore, the PSA argued:

> "It is of note that neither our Standards, nor the FPPT, whether in its original or updated incarnation, were aimed at managers below board level– this part of the recommendation seems to have been widely overlooked. Mechanisms resulting from this recommendation have focused on Board-level directors, and always stopped short of any kind n of statutory scheme–

97 NHSE, NHS leadership competency framework for board members, February 2024
98 A review of the Fit and Proper Person Test (the 'Kark review') (February 2019)
99 The Professional Standards Authority (PSN0021)

> whether a public 'negative register' of individuals who have been barred, or a full regulatory scheme like that for doctors. Our Standards were never put on any formal footing and appear to have fallen out of use."[100]

Several NHS organisation stakeholders that responded to whether the commitment had been met referred to the Nolan Principles of public life,[101] the FTTP,[102] professional registration governing the conduct of individual board members and guidance such as "civility saves lives"[103] and "living our values booklet"[104].[105] The Nolan Principles was established in 1995, many years ahead of the recommendation being made and implemented. The FTTP (recommended and accepted in 2019) and the toolkit for civility and respect (current version was launched in 2021[106]) were introduced following this recommendation being made. The NHS values and principles were first set out in the NHS Constitution published in 2013[107] (the same year as the recommendation was made).

The Midlands Patient Safety Research Centre referred to the professional regulation via the General Medical Council (GMC) of managers who are also doctors, and the ability for an employer to monitor managers' compliance with professional standards and if needed make a complaint. They further stated that "using such systems effectively may be higher priority than developing a new one".[108] The Royal Pharmaceutical Society similarly referred to the professional regulation of pharmacists as example of the recommendation being met.[109]

RCOG and the RCM however argued that although FPPT and other guidance are "in keeping with the spirit" of the recommendation, they concluded that these:

> *"[…] fall short of being a code that employers could be expected to enforce. While the standards remain as a live document on the PSA's website, there does not appear to have been any further iterations or updates since they were first published in November 2013."*[110]

One of the participants during our roundtable was not positive regarding the enforcement of a common code of conduct where they worked in the NHS:

> *"My experience is that these codes and ethics and so on are just widely ignored. And certainly at the moment we have a situation where, I have to say I don't really fully understand the power structures within trusts, but certainly where two governors who have been asking questions about standards on the board have been suspended, and another one forced in to resignation. So I don't really see the structures being in place to hold executives to the code of conduct that we would expect."*[111]

100 The Professional Standards Authority (PSN0021)
101 UK Government, The Nolan Principles, 31 May 1995
102 NHSE, 'NHSE fit and proper person test framework for board members', accessed 29 February 2024
103 NHSE, 'Civility and Respect', accessed 29 February 2024
104 For example: NHS North West Anglia, Living our values booklet (February 2021)
105 NHS Norfolk and Waveney ICB (PSN0009); NHS North Central London ICB (PSN0014); NHS Frimley ICB (PSN0015); NHS Suffolk and North East Essex ICB (PSN0018)
106 NHS, Supporting Our Staff – A Toolkit to Promote Cultures of Civility and Respect (October 2021)
107 NHS, The NHS Constitution (March 2013)
108 The Midlands Patient Safety Research Centre (PSN0010)
109 The Royal Pharmaceutical Society (PSN0019); NHS Gloucestershire ICB (PSN0020)
110 The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (PSN0024)
111 Expert Panel roundtable – Group 1

Another roundtable participant stated:

> *"[…] with the code of ethics, it is written down, it is clear what it is. But people have been in professions way longer than this has been introduced. So maybe then when you're recruiting and you're holding people to account in a certain way. But there seems - and maybe this is just my personal experience - but there is acceptance of behaviours of people who have been in post a long time. And it's just how they do it, it's just what they're like. And to challenge that "this is our mark in the sand and this is how we're moving forward" seems to be really challenging line for any board to take. Especially if you're then expecting people who've been on that board for a long period of time, who have allowed this behaviour, to then say, "well, now we're not allowing it"."*[112]

The Government's submission stated that this recommendation has been implemented, and points to a range of initiatives including the Secretary of State commission to the PSA to produce "a series of standards for senior board-level leaders and managers", a 2023 NHSE code of governance and the FPPT. The submission also sets out that the Government is "currently exploring whether further mechanisms are needed to hold NHS managers accountable", and that those actions would be considered alongside the recommendations made in the Messenger review.[113]

The recommendation referred to the existence of a code and to steps to ensure compliance and enforcement. Based on the evidence we have received, we cannot conclude that this recommendation has been fully implemented or that the progress so far has been wholly satisfactory. We therefore conclude that it requires improvement.

Was the recommendation effectively funded (or resourced)? Rating: Requires improvement

We received very limited evidence regarding whether this recommendation had been effectively funded or resourced. The Government's response stated that it has and that NHSE provides national investment in initiatives to "support board effectiveness", and that local Trusts "make their own decisions on board level investment".[114] There is evidence of support mechanisms including training and development[115] and investment in the new NHS Leadership Competency Framework for board level roles.[116] However, funding to transform principles and frameworks into practice is particularly important in light of concerns as to effective implementation. As such we grade this area "requires improvement".

Did the implementation of the recommendation achieve positive impacts for patients and people in receipt of social care? Rating: Requires improvement

Sands and Tommy's Joint Policy Unit stated that:

112 Expert Panel roundtable – Group 1
113 Department for Health and Social Care (PSN0027)
114 Department for Health and Social Care (PSN0027)
115 NHSE, 'Directory of board level learning and development opportunities', accessed 4 March 2024
116 NHSE, 'NHS leadership competency framework for board members', accessed 4 March 2024

> *"As providers of services, the safety and quality of maternity and neonatal services are ultimately the responsibility of Trust boards. Trust leadership at the executive and board level is reviewed by the CQC during inspections. However, failures in board leadership continue to be identified in reviews and inquiries."*[117]

One of the participants in our roundtable, who lost a child due to issues in patient safety, told us:

> *"It's like the duty of candour about saying sorry - well everyone is sorry my child is dead, but what does that mean to you? What does it mean in real terms? Of course you're sorry, but what does sorry mean to you? And I think it is the same with the ethics, we can instil rules, and plans, and tick box exercises for people to follow, but do they actually follow it? And who follows them up to know that they're following it? It just doesn't happen, and it just feels like more and more bureaucracy layered upon more and more bureaucracy, and I feel really sad that we're in a world, in the 21st century, 10 years after my child's death, that we are having to put in a rule to mitigate against not being listened to."*[118]

The Government's response stated that it is "difficult to quantify" whether the implementation of this recommendation has had a positive impact on patients and service users, and added:

> *"[…] seeing the longer- term impact on patients and staff, their experiences and outcomes, will take time and is factored into ongoing evaluation of the work."*[119]

Based on the evidence available to us, we do not conclude that the processes of implementing this recommendation have so far achieved fully positive impact for patients and service users. Whilst there is evidence of progress we consider there is still more work to do, and we therefore rate this area 'requires improvement'.

Was the recommendation interpreted appropriately? Rating: Requires improvement

Only a few stakeholders provided views regarding to what extent the Government had interpreted the recommendation appropriately. The Medical Protection Society stated:

> *"Senior board-level healthcare leaders and managers have a huge impact on the organisations that they lead. They are at the helm of not only the Trusts that they manage, but the community that stems from these Trusts as well; the culture, environment and behaviour of other staff and colleagues are influenced by their conduct and actions. When problems occur, the lack of regulation and standardisation makes it difficult to hold senior level managers accountable. The 'revolving door' of senior NHS management also makes this problematic."*[120]

117 Sands and Tommy's Joint Policy Unit (PSN0023)
118 Expert Panel roundtable – Group 3
119 Department for Health and Social Care (PSN0027)
120 The Medical Protection Society (PSN0013)

The PSA stated:

> *"[…] there is still a great deal of concern about the arrangements for NHS managers. We conclude from the above that policy development and resulting implementation in this area have been plagued by flaws."*[121]

During our roundtable, Christine Braithwaite from the PSA argued that there had been a continued "mismatch" between what the PSA had produced, how it was used and what the Government considered it to be:

> *"[The PSA was] only asked to develop the standards, not to have a role in the implementation of them. And from our perspective, that's where the mismatch happened, in that standards were produced, and they went through a very consultative process to arrive at those. They included a pledge at the beginning to make it clear that patient safety was at the beginning of those. Subsequently however, the Fit and Proper Person Test, that might have been a way of enforcing them, didn't use the standards that we'd produced. So there was immediately a mismatch between the standards and the implementation of those. And our understanding is that the uptake of the standards generally was quite patchy. So some people were aware of them, but in general there seemed to be low awareness of it. And it wasn't very clear that, you know, "these are now the new standards, previous versions of any kind of standards are hereby revoked" as it were. So it was left with a rather patchy picture of implementation."*

Other participants during our roundtable similarly spoke to the issues regarding oversight and enforcement, seeing as some managers on board level would be overseen by a professional regulator (if they were a nurse or doctor for example), whilst others would not.[122]

The Government, and other stakeholders, have pointed to the FPPT in this context. In the executive summary of the report commissioned to review FPPT, the authors conclude that their review had "revealed few fans of the Fit and Proper Person Test (FPPT) as it is currently applied", and that some considered it "just another hoop to go through which has no real effect on patient care or safety." The review makes a series of recommendation on how to address issues regarding the FPPT.[123] In response to the Kark Review, the NHS published the Fit and Proper Persons Framework, which according to the NHSE website will seek to introduce:

> *[…] a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.*[124]

Sam Foster of the Nursing and Midwifery Council felt the new framework was an improvement, but there were still gaps in the regulation of non-clinical senior staff:

121 Professional Standards Authority (PSN0021)
122 Expert Panel roundtable – Group 2
123 A review of the Fit and Proper Person Test (February 2019)
124 NHSE, NHSE fit and proper person test framework for board members (September 2023)

> *I think the new framework has got more teeth. I've certainly seen changes at Board level and Fit and Proper Persons. We've all seen the impact of Well-Led. But the new one, I think, has more teeth. But I think there's an opportunity to extend it wider than Board members. And as we've all said, clinicians in senior leadership positions - there's more anchor points that we can use around expectation. But there's certainly a gap for the non-clinical.*[125]

In our roundtable discussion, Tom Kark KC commented that the implementation of his recommendations in relation to the FPPT had happened through guidance rather than in law:

> *"I'm very conscious that the first four recommendations that I made in relation to setting up a set of core competencies; having a proper database; having mandatory references so you can't have vanilla references; following a compromise agreement; extending the Fit and Proper Person test to ALBs [arms length bodies]. All of that has actually not been done by legislation, but has been done by guidance."*[126]

He went on to talk about the lack of implementation of his recommendation that would allow the disqualification of health directors found guilty of serious misconduct:

> *"[…]the big one, Recommendation 5 (which was–and I understand that this would be very challenging - to set up a limited regulator, so that you can actually disqualify health directors who have been found guilty of serious misconduct) obviously hasn't happened."*[127]

Mr Kark went on to say that in his opinion, legislation was needed if the code of conduct was going to be really effective. Our Chair, Professor Dame Jane Dacre concluded that the code of conduct looks good, but questioned whether it could or should be strengthened through legislation, to which Mr Kark responded:

> *"Yes, indeed. And also one has to remember all of this is just framed as guidance. I take it from what [roundtable participant] has been saying, that the guidance is actually being taken seriously, which is very good to hear. But for anything else, legislation would be needed."*[128]

The Government's response stated that "interpretation and implementation of the recommendation was appropriate, but work continues to further strengthen leadership across the NHS."[129]

In summary, it seems to us that the Government has accepted the recommendation but not approached it in a way which stakeholders consider satisfactory. Many of the mechanisms in place to better hold board level members to account have not been fully implemented, and there seems to be an issue in overseeing whether board level members meet these standards. Based on the, limited, evidence we received in regard to whether this recommendation had been interpreted appropriately we conclude that this 'requires improvement'.

125 Expert Panel roundtable – Group 2
126 Expert Panel roundtable – Group 2
127 Expert Panel roundtable – Group 2
128 Expert Panel roundtable – Group 2
129 Department for Health and Social Care (PSN0027)

2 Training of staff in health and social care

Accepted Recommendation	A. Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
"Targeted interventions on collaborative leadership and organisational values, including a new, national entry-level induction for all who join health and social care." (From the Health and social care review: leadership for a collaborative and inclusive future report, 2022)	Requires improvement	Inadequate	Requires improvement	Good	Requires improvement

In this section we provide an assessment of the Government's implementation of the following recommendation in relation to training of staff in health and social care:

"Targeted interventions on collaborative leadership and organisational values, including a new, national entry-level induction for all who join health and social care." (From the Health and social care review: leadership for a collaborative and inclusive future report, 2022)

The recommendation is from Health and social care review: leadership for a collaborative and inclusive future report, published in June 2022. This was an independent review of leadership across health and social care in England conducted by General Sir Gordon Messenger and Dame Linda Pollard. The review is also referred to as the Messenger Review.[130]

In October 2021 the then Secretary of State for Health and Social Care the Rt Hon Sajid Javed MP commissioned former Vice Chief of the Defence Staff General Sir Gordon Messenger to review the state of leadership and management in the health and social care sector. Although the report is independent of Government, General Messenger was supported by "a team from DHSC and the NHS […] led by Dame Linda Pollard, chair of Leeds Teaching Hospital.[131] A 2021 press release by the Department stated the aims of the review to "consider how to foster and replicate the best examples of leadership" and "to reduce regional disparities in efficiency and health outcomes across the country". However the Department also stated, "The review will also look at how to deliver the findings of proposals and commitments made in previous reports on leadership."[132]

The review report was published online on 8 June 2022 along with the following statement from the Department:

130 Independent Report - Health and social care review: leadership for a collaborative and inclusive future (June 2022)

131 "Government launches landmark review of health and social care leadership", Department of Health and Social Care press release, 2 October 2021

132 "Government launches landmark review of health and social care leadership", Department of Health and Social Care press release, 2 October 2021

> *"All 7 [report] recommendations have been accepted by the government and publication of the report will be followed by a plan committing to implementing the recommendations."*[133]

Overall Recommendation Rating and Overview: Requires improvement

The recommendation comes under the heading "Targeted interventions on collaborative leadership and organisational values" within the Messenger Review. It identifies the need for new training for staff to support the changes in health and care delivery that came with the introduction of Integrated Care Systems, which became statutory under the Health and Care Act 2022.[134]

The review report states that the training should support the development of more collaborative behaviours and emphasised the need for improved and standardised training for staff on equality, diversity and inclusion. The review identified two "critical waypoints" where training could make a significant impact: at entry to a health and social care career, and at mid-career.

The recommendation for entry-level induction training covers everyone entering a role in healthcare, social care, local government or relevant voluntary and private sector organisations. It includes staff entering the workforce as part of formal programmes such as the Graduate Management Training Scheme[135] and the Assessed and Supported Year in Employment programme.[136] According to the review, the aims of the induction training should be " … to introduce new starters to the culture and values that are expected within services and to foster a sense of belonging wider than the immediate organisation."[137]

The review sets out that the induction training should be created collaboratively by "partners across health and social care including NHSE, the Department, the Local Government Association,[138] Skills for Care,[139] staff networks and patient representatives".[140] The review recommends that the framework governing the training should be set nationally, with some allowance for local variation and should be implemented together with local inductions. However the review sets out that the training should also be made universally available for consistency. While the review is clear that new training is required, rather than the scaling-up of existing training, the review also indicates that the induction training for social care could build on the Care Certificate standards.[141]

133 DHSC, 'Health and social care review: leadership for a collaborative and inclusive future', accessed 27 February 2024

134 Health and Care Act 2022, section 31, Part 1

135 NHSE, 'NHS Graduate Management Training Scheme ', accessed 26 February 2024

136 Department for Education, 'Assessed and supported year in employment', accessed 26 February 2024

137 Independent Report - Health and social care review: leadership for a collaborative and inclusive future (June 2022)

138 The Local Government Association is a representative organisation for local councils. See Local Government Association "About" accessed 20 February 2024

139 Skills for Care is the strategic workforce development and planning body for adult social care in England. See Skills for Care "About us", accessed 20 February 2024

140 Independent Report - Health and social care review: leadership for a collaborative and inclusive future (June 2022)

141 Independent Report - Health and social care review: leadership for a collaborative and inclusive future (June 2022)

The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.[142] The standards are designed for the non-regulated health and social care workforce, because staff in regulated professions such as doctors, nurses, social workers and occupational therapists, gain similar knowledge and skills during their professionally-regulated training.[143] According to Health Education England (HEE), now subsumed into the NHSE Workforce, Training and Education Directorate,[144] the Care Certificate aims to give " … everyone the confidence that health and care professionals have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support in their own particular workplace setting."[145]

The Care Certificate was created in response to concerns about patient safety raised in the 2013 Francis Inquiry report, which recommended a national code of conduct and national standards of training for healthcare support workers,[146]and then confirmed in the 2013 Cavendish Review.[147] The Cavendish review, formally called the Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings, was commissioned in 2013 by the then Secretary of State to identify how to ensure unregistered staff in the NHS and social care treat all patients and clients with care and compassion.[148]

In 2019, prior to the Messenger Review, NHSE (then HEE) commissioned an NHS-wide Patient Safety Syllabus, which was co-developed by the Academy of Medical Royal Colleges (AoMRC)[149] and published in 2021.[150] According to an HEE frequently asked questions document, the syllabus is "intended to cover all the patient safety training and educational needs of people currently working in the NHS or in training to work in the NHS."[151] The HEE document specifies that the scope of the training "includes both clinical staff and the wider health and care workforce and covers the voluntary sector and social care".[152] The training developed as part of this syllabus is available online on the NHSE eLearning for health hub.[153] Level 1 training entitled 'Essentials for patient safety' is referred to as the starting point, and while not mandatory, information on the NHSE website about the training states that "all NHS staff are encouraged to complete it."[154] Level 1 provides an additional session for senior leaders that covers the essentials of patient safety for boards and senior leadership teams. Level 2 training entitled 'Access to practice' is "intended for those who have an interest in understanding more about patient safety and those who want to go on to access the higher levels of training".[155]

In November 2023 the Minister of State for Health Andrew Stephenson MP was asked by Rachael Maskell MP, about the steps the Department was taking to implement the recommendations of the Messenger Review. In response the Minister said that all the

142 Skills for Care, 'Care Certificate', accessed 21 December 2023
143 Skills for Care, 'The Care Certificate Standards', accessed 21 December 2023
144 NHSE, 'Workforce, training and education', accessed 26 February 2024
145 Health Education England, 'Care Certificate', accessed 21 December 2023
146 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry , February 2013
147 Health Education England, 'Care Certificate', accessed 21 December 2023
148 The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings, (July 2013)
149 NHSE and Improvement, The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients (July 2019)
150 Academy of Medical Royal Colleges, National patient safety syllabus 2.0 (May 2021)
151 NHSE, 'NHS patient safety syllabus and training - Key FAQs Levels 1 and 2', accessed 26 February 2024
152 NHSE, 'NHS patient safety syllabus and training - Key FAQs Levels 1 and 2', accessed 26 February 2024
153 NHSE E-learning for health, 'Patient Safety Syllabus Training', accessed 26 February 2024
154 NHSE, 'Patient Safety', accessed 7 March 2024
155 NHSE E-learning for health, 'Patient Safety Syllabus Training', accessed 26 February 2024

review recommendations had been accepted by Government, and NHSE was leading on the implementation of the recommendations, in partnership with Skills for Care for those that apply to the social care workforce. He stated that the implementation of the recommendation and the introduction of the new training includes:

- A new national induction scheme for staff of all grades who join health and social care, to be launched in April 2024.
- A management and leadership framework being developed for consultation and extensive testing by March 2024, comprising management code, professional standards and management competencies at five levels, from entry level to executive manager.[156]

Skills for Care provide further details on its website, where they state that they and NHSE will both publish resources to support induction and leadership across health and social care. The resources will focus on collaboration, inclusion and compassion. According to Skills for Care, these resources will be published "in Spring 2024".[157]

According to Skills for Care, the induction resources include:

- A new national entry-level induction for individuals joining health and social care, in the form of an online resource free for new and existing staff that will introduce staff to health and social care and the connections between the two sectors, including shared cultures and values. The induction is not mandatory, but its adoption is "highly recommended". It will not duplicate or replace the Care Certificate or formal qualifications.
- Resources for managers for managers to support induction.[158]

The leadership resources include:

- The development and testing of a voluntary code of conduct for managers
- "Approaches and resources" which embed equality, diversity and inclusion across health and social care.[159]

During our roundtable, the co-chair of the Messenger Review Dame Linda Pollard expressed frustration with what she felt was the lack of an effective implementation strategy for the review's recommendations:

> *"The agreement [of the recommendations] was at the point when [Secretary of State] Sajid Javid had it, was that we would move to Implementation Board. And the Implementation Board was going to be made up with both the Department and NHSE. And it would be holding whoever to account for delivery.[…] What's happened now is that it moved from implementation to Advisory Group[…] that sits within NHSE. It's a four-year plan. The first year was last year. […] But when we come to implementation, that's another question, it's my frustration as well, because it's not an implementation*

156 HC Deb, 14 November 2023, col UIN1917
157 Skills for Care, 'Induction and leadership support in 2024', accessed 20 February 2024
158 Skills for Care, 'Induction and leadership support in 2024', accessed 20 February 2024
159 Skills for Care, 'Induction and leadership support in 2024', accessed 20 February 2024

> *group, it's an advisory group. So the pace by which we've been able to go through this whole period has been cripplingly slow. We have got to the point where Year 1 was all the kind of work that was being done and progressing to what is now a three-year plan, my comment would be that, Year 2 and 3 - there is so much to deliver. And this would be delivered ostensibly by NHSE with other partners that would have to be commissioned to do it. And I think my real concern is that there isn't either the capacity or the resource within NHSE - they've just had, obviously, a massive reorganisation themselves - to deliver on this."*[160]

We have rated the Government's implementation of this recommendation as 'requires improvement' overall. We agreed with the view of many stakeholders that the Department and NHSE's work regarding training of staff is important and will likely deliver benefits. We also recognise the progress to date in developing online induction training and resources for all staff across health and social care, which is due to be launched after a short delay in April 2024. However, we did not receive evidence to reassure us that the induction training was to be implemented consistently across providers, particularly within social care. There has been some funding from the Department to engage the care sector with the implementation, however the amount of funding has not been specified to us, and we have seen no evidence of funding to enable staff to take up the training. Staffing issues (as we outlined in our report looking at the health and social care workforce[161]) continue to challenge both the health and social care sectors. This creates difficulties for staff wanting to take up training, and can also hamper staff being able to translate the benefits from training to patients and people in receipt of care. We are unconvinced that the funding and resourcing of the implementation of the recommendation is sufficient.

Was the recommendation implemented (or on track)? Rating: Requires improvement

Stakeholders informed us that the national entry-level induction and national leadership training were not yet in place,[162] however the induction training was expected to be launched in spring 2024.[163] NHS Cornwall and Isles of Scilly ICB stated that launch had been expected earlier but that it had been delayed.[164]

The Health Services Safety Investigation Body (HSSIB) have a remit that includes providing "training and support to NHS staff to help equip them to better investigate patient safety events and understand safety from the systems perspective". They outlined their work with the AoMRC to develop "the new NHSE mandatory training in essentials for patient

160 Expert Panel roundtable – Group 2

161 The Health and Social Care Select Committee, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of the health and social care workforce HC 112 (July 2022),

162 Dementia UK (PSN0006); The Royal College of Physicians of Edinburgh (PNS0011); NHS Norfolk and Waveney ICB (PSN0009); NHS North Central London ICB (PSN0014); NHS Cornwall and Isles of Scilly ICB (PSN0017); NHS Gloucestershire ICB (PSN0020); The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (PSN0024)

163 NHS Norfolk and Waveney ICB (PSN0009); NHS Cornwall and Isles of Scilly ICB (PSN0017); NHS Gloucestershire ICB (PSN0020); The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (PSN0024)

164 NHS Cornwall and Isles of Scilly ICB (PSN0017)

safety and essentials of patient safety for boards and senior leadership teams", which they said helps "to provide a foundation basis to understand safety and some of the concepts required to help make NHS care safer for all."[165]

From the evidence we have seen, it is clear that national organisations, NHS ICBs/ICSs (integrated care systems), and their constituent organisations provide their own induction and leadership training for health and care staff.[166] For example:

- For pharmacy professionals, the Royal Pharmaceutical Society has a Leadership Development Framework, which "outlines behaviours of effective, engaging leadership and mirrors the NHS Leadership Academy's Healthcare Leadership Model". The Centre for Pharmacy Postgraduate Education also provides internally produced leadership training resources.[167]
- For social care staff, NHS Norfolk and Waveney ICB and NHS North Central London ICB indicated that the Care Certificate is used widely to support entry-level care skills, and contains some core content for social care staff, such as safeguarding."[168]
- At a system level, NHS Frimley ICB informed us about "work being undertaken across the system on local induction staff for entry level health and social care staff".[169] NHS Norfolk and Waveney ICB indicated that they were working across health and social care within their system to coordinate leadership development, and also to pilot the NHS 'Scope for Growth'[170] career conversation tool to support career development, retention and talent management.[171]

It was not however clear to us how the consistency and quality of existing induction and leadership training is assured across providers and staff groups across health and social care, or how this would affect the introduction of the induction course developed in response to the recommendation. NHS Norfolk and Waveney ICB told us that individual organisations within their system have their own approaches to leadership development that reinforce what is done as a system.[172] By contrast NHS Gloucestershire ICB described how each organisation within their system has its own training which can lead to variable training approaches.[173]

We also heard from stakeholders that although patient safety e-learning modules and training resources were available to all NHS staff, these were not always mandatory,[174] which arguably increases the chance that some staff will not undertake them. While we recognise the point made by the Royal College of Physicians of Edinburgh, that making

165 The Health Services Safety Investigation Body (PSN0004)
166 The Royal College of Physicians of Edinburgh (PNS0011); Dementia UK (PSN0006); NHS North Central London ICB (PSN0014); NHS Frimley ICB (PSN0015); NHS Gloucestershire ICB (PSN0020); NHS Norfolk and Waveney ICB (PSN0009)
167 The Royal Pharmaceutical Society (PSN0019)
168 NHS Norfolk and Waveney ICB (PSN0009); NHS North Central London ICB (PSN0014)
169 NHS Frimley ICB (PSN0015)
170 NHS South West Leadership Academy 'Scope for Growth', accessed 26 February 2024
171 NHS Norfolk and Waveney ICB (PSN0009)
172 NHS Norfolk and Waveney ICB (PSN0009)
173 NHS Gloucestershire ICB (PSN0020)
174 NHS Gloucestershire ICB (PSN0020); NHS Norfolk and Waveney ICB (PSN0009); The Royal Pharmaceutical Society (PSN0019)

training mandatory does not necessarily make it useful,[175] we are concerned that some staff may miss training completely. Indeed, the HSSIB told us about their ongoing investigation which found that temporary NHS staff do not always receive induction on "wider values, safety, and cultural expectations of the employing NHS organisation".[176] We also heard about the need to tailor training to the needs of staff with English as an additional language.[177]

As in our previous evaluations,[178] we heard about other challenges that prevent health and social care staff from accessing and benefitting from training. Most notable challenges include staff shortages and lack of time in job plans.[179] Dementia UK outlined the particular challenges that need to be overcome to ensure social care staff can benefit from training. They described how the lack of "standardised, national level training programmes" exemplified and compounded the general lack of training and development available to the social care workforce. They argued that the social care workforce suffers from under-investment in staff development and workforce gaps which make it harder for existing staff to undertake training. They pointed to the lack of a social care workforce plan akin to the NHS Long Term Workforce Plan and indicated that more than half of direct care staff lack a qualification.[180] We note that Skills for Care are currently developing a long-term workforce plan for social care, which is chaired by Core Panel member Sir David Pearson.[181]

In our roundtable, we heard how the induction training being developed in line with the recommendation was difficult to implement across social care provided because of different accountability structures and incentives for social care providers:

> *"So there is a core induction being developed across health and social care as part of the Messenger Review. It's hard to implement that in social care, obviously, because of the lack of levers, and it's an employer's responsibility. And at the minute obviously induction is quite variable … . And then there's something for me about how much the market incentivises collaboration in social care, a market that is that pays for activities and not outcomes. And that makes it a slightly different context, I think."*[182]

As we have also found in our previous evaluations,[183] poor IT infrastructure can create problems for training. For example, NHS Gloucestershire ICB told us that their new online national patient safety training programme was delivered through a platform not used by all organisations within their system, which caused a delay in integrating the training into the ICB's statutory and mandatory training regime.[184]

175 The Royal College of Physicians of Edinburgh (PNS0011)
176 The Health Services Safety Investigation Body (PSN0004)
177 Dementia UK (PSN0006)
178 The Health and Social Care Select Committee, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of the health and social care workforce HC 112 (July 2022); The Health and Social Care Select Committee, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's commitments in the area of pharmacy in England HC 1310 (July 2023),
179 The Royal College of Physicians of Edinburgh (PNS0011); The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (PSN0024); Sands and Tommy's Joint Policy Unit (PSN0023)
180 NHSE, NHS Long Term Workforce Plan (June 2023)
181 Skills for Care "Skills for Care to develop workforce strategy for adult social care – as new report shows a year of 'green shoots' and ongoing challenges", accessed 13 March 2024
182 Expert Panel roundtable – Group 1
183 The Health and Social Care Committee, The Health and Social Care Committee's Expert Panel: Evaluation of Government commitments made on the digitisation of the NHS HC 780 (February 2023)
184 NHS Gloucestershire ICB (PSN0020)

The Department and NHSE submission stated that the recommendation "is in the process of being implemented".[185] It confirmed that the new induction framework for all those joining the NHS and social care will be launched "in Spring 2024", explaining that the induction framework is set at a national level but allowing local variation, and "there is scope" within the framework "to build on the Care Certificate Standards". The submission provided some detail about the content of the framework, which provides:

- information about the sectors available to staff before they start,
- a "structured pathway" to support staff through their first 3–6 months; resources for managers, to help them fit the universal induction within local induction processes,
- "a set of resources to enable a collaboration activity at place level in systems", and
- a resource library.[186]

In their follow-up written submission, the Department gave further details about the roll out of the induction and other related training within social care. They stated that to prepare for the launch of the induction, awareness-raising activities have been taking place with social care employers and stakeholder groups informed by "a detailed communications and engagement plan". They also stated that a Care Workforce Pathway had been published in January 2024, which sets out the knowledge, skills, values and behaviours needed to work in adult social care, as well as learning and development opportunities for staff. The Pathways includes the 'new to care' role category which, according to the Department "aligns with the National Induction in Messenger". As part of the Pathway, staff joining the sector as social care and support workers will be "encouraged" to complete a new Level 2 Care Certificate apprenticeship in their first year.[187]

With regards to the national mid-career programme for managers across the NHS and social care, the Department highlighted the role of the NHS Patient Safety Syllabus training. It reported that, following an independent evaluation, the functionality and accessibility of the Levels 1 and 2 training was improved, certificates of completion were added, and that "sector specific sessions covering acute care, maternity, primary care, mental health, and management and administration were also added in April 2023." Between September 2023 and October 2024, Levels 3 and 4 of the training will be delivered to 820 staff (primarily Patient Safety Specialists) by Loughborough University online and in person.[188] In their supplementary evidence to us, the Department provided approximate figures for the number of staff who had undertaken this training as of February 2024:

- 855,000 (around 61% of all 1.4m NHS staff) had completed Level 1;
- 42,000 had completed the Essentials of patient safety for boards and senior leaders;
- 430,000 had completed Level 2;

185 Department for Health and Social Care (PSN0027)
186 Department for Health and Social Care (PSN0027)
187 Supplementary written evidence submitted by the Department of Health and Social Care (PSN0029)
188 Department for Health and Social Care (PSN0027)

- 900 are signed up to Levels 3 and 4.[189]

The Department also set out that, within social care, it has agreed to review the existing Managers' Framework with the aim of "supporting greater consistency in management standards across health and care settings". The Department added that information from the revised Managers' Framework will be incorporated into the "next phrase of the Care Workforce Pathway which includes deputy and registered manager roles". The Department aims to "move to implementation" of this Pathway from mid-2024.[190]

Based on the evidence available to us, we conclude that aspects of the induction training included within the recommendation will be implemented with a short delay. However, we did not find evidence of a plan for implementing this induction training within social care, nor did we receive evidence about how the induction and leadership training will be integrated with the wide variety of existing training being developed and delivered across different organisations. We therefore rate this aspect of the implementation as 'requires improvement'.

Was the recommendation effectively funded (or resourced)? Rating: Inadequate

We received relatively little evidence from stakeholders about funding specifically for the implementation of the recommendation, however the evidence we did receive indicated it was unlikely to be sufficient for the scale of the offer of induction for all health and social care staff and the practical implementation issues this raises, particularly among independent social care organisations. We note the concerns we have from stakeholders about the funding issues that particularly affect the social care workforce.[191]

A National Audit Office (NAO) report on adult social care published in November 2023 stated that the Department had in April 2023 halved funding for workforce reforms including training, qualifications and staff wellbeing " … from £500 million to "at least" £250 million."[192]

Without additional funding to implement the recommendation, we heard that ICB's will need to divert funds and staffing away from existing training and staff development to meet the recommendation.[193]

The Department's submission indicated that "specific and adequate" funding has been available for implementation of the recommendation. Relating to the induction training, the submission stated that "funding to develop the component product has been sufficient to develop product that can be expanded and built upon.". The submission added that "costs have been kept to a minimum, utilising internal expertise and partnership working in health and social care."[194]

In their supplementary evidence, the Department stated that within social care, "further funding" had been agreed with Skills for Care "to continue their sector engagement activity

189 NHSE (PSN0028)
190 NHSE (PSN0028)
191 Dementia UK (PSN0006); NHS Cornwall and Isles of Scilly ICB (PSN0017); NHS Norfolk and Waveney ICB (PSN0009)
192 National Audit Office, Reforming adult social care in England , Session 2023–24 HC184
193 NHS Frimley ICB (PSN0015); NHS Cornwall and Isles of Scilly ICB (PSN0017)
194 Department for Health and Social Care (PSN0027)

to promote the national induction activity during 2024/25. This will include a national webinar, presentations, social media messaging and briefings, incorporating frequently asked questions and other local intelligence and insights, to inform best practice and encourage collaboration across local systems."[195]

The evidence we have received indicates that the implementation of this recommendation has not received additional funding within the NHS or social care with the exception of an unspecified amount to Skills for Care to provide some initiatives and communications within the care sector. Whilst we welcome the funding provided to Skills for Care, it is unclear how the recommendation will be implemented in social care, across 152 local authorities and nearly 18,000 providers, in a way that aligns with implementation in the NHS. We therefore conclude that the funding for the implementation of the recommendation is inadequate.

Did the implementation of the recommendation achieve positive impacts for patients and people in receipt of social care? Rating: Requires improvement

This recommendation is not due to be implemented until spring 2024 and as such the evidence focusses on projected impact. We share the optimism of many of our respondents that training will have a positive impact, but also their concerns around implementation, responsiveness, funding and monitoring.[196]

The submission we received from NHS Frimley ICB provided evidence of the positive impacts they have seen from their own local leadership training programme is having on patients, including reducing hospital discharge times, improving health inequalities and positive evaluations from attendees.[197] However this programme is not currently part of the new training being implemented as a result of the recommendation, and it is unclear to us whether the need to divert resources from existing training budgets to implement the recommendation will affect its continued success.

We consider that the varying degree at which existing training is delivered,[198] as well as the variation in the training needs of staff across health and social care, means that considerable efforts will be needed to ensure the benefits from the implementation of the recommendation is experienced by all health and care staff, and those they care for. Some ICSs are making efforts to ensure training is delivered consistently across health and social care, by commissioning and delivering training and education to support skills development across sectors and locations.[199] However, we were not able to establish from the evidence we received how widespread or effective these efforts were.

Furthermore, without additional measures to ensure staff shortages do not prevent staff from gaining the full benefits of training, we conclude the potential benefits of the recommendation to patients and people in receipt of social care are unlikely to be fully realised. As the RCOG and RCM put it in their submission:

195 Supplementary written evidence submitted by the Department of Health and Social Care (PSN0029)
196 Dementia UK (PSN0006), NHS Norfolk and Waveney ICB (PSN0009); The Royal College of Physicians of Edinburgh (PNS0011)
197 NHS Frimley ICB (PSN0015)
198 NHS Gloucestershire ICB (PSN0020)
199 NHS Norfolk and Waveney ICB (PSN0009); NHS Frimley ICB (PSN0015)

> *"With little opportunity for CPD [continuing professional development] […] many staff were unable to develop the breadth and depth of knowledge and practice, which would equip them with the learning, skills and confidence to give women and families the safest and best quality care."*[200]

The Department and NHSE submission stated that an "evaluation plan" is being developed to better track uptake and satisfaction of the induction framework, and they anticipate that the induction training "will positively impact early attrition from NHS and social care roles by providing consistent support and information for new joiners."[201] In their supplementary evidence, the Department provided some more information about how they plan to monitor and evaluate the induction within social care:

> *"We will agree Key Performance Indicators (KPIs) to support the monitoring and evaluation of that [induction] activity and any read across to the Care Workforce Pathway, for example staff progressing into more senior leadership/ management roles, who may require additional support and development."*[202]

However, it was clear that the evaluation of the induction's effectiveness within social care has not been built-in to the development of the training:

> *"We are still considering how best to assess what impact the new induction arrangements have had in social care, including any resulting improvements to recruitment and retention and how engaged social care employers are in maintaining a shared approach with health and how effective this is proving"*[203]

With regards leadership training, within social care the Department stated that they had agreed to review the current Managers' Framework "with a view to supporting greater consistency in management standards across health and care settings". They added:

> *"We are also co-developing with Skills for Care and the sector, the next phase of the Care Workforce Pathway which includes deputy and registered manager roles, which will enable relevant information from the refresh of the Managers' Framework to be incorporated into the Pathway as we move to implementation from mid-2024."*[204]

The Department provided no evidence about the impact of existing patient safety training or about plans to evaluate the new leadership training.

We consider that the implementation of the recommendations is likely to have some positive benefits to staff and therefore to patients and people in receipt of care, however the lack of evidence in this area leads us to rate this aspect of implementation as 'requires improvement'.

200 The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (PSN0024)
201 Department for Health and Social Care (PSN0027)
202 Supplementary written evidence submitted by the Department of Health and Social Care (PSN0029)
203 Supplementary written evidence submitted by the Department of Health and Social Care (PSN0029)
204 Supplementary written evidence submitted by the Department of Health and Social Care (PSN0029)

Was the recommendation interpreted appropriately? Rating: Good

The evidence we received indicated stakeholders were generally positive about the need for national induction and leadership training.[205] NHS Gloucestershire ICB stated that the existing Level 1 and 2 training sets "a baseline which promotes the idea of 'safety'", which they argued "can only be seen as good thing".[206]

NHS Norfolk and Waveney ICB were "strongly" supportive of the induction and mid-career development programme, particularly of the inclusion of social care and health staff within the same training programmes.[207] The Royal College of Physicians of Edinburgh similarly considered that the "unification" of leadership qualifications across health and social care was welcome given the need to do more to share goals and targets".[208]

NHS Frimley ICB agreed that the implementation of the recommendation was appropriate but argued the qualifications "could go further" to integrate national and local frameworks, allowing "local system flexibility for context relevant initiatives and induction to coexist in the detail."[209] The RCM and RCOG also wrote that while the induction was welcome, it was not enough and "new staff should be able to experience a period of further development and confidence building" for example midwives should have "a period of preceptorship to complement any formal induction and orientation programmes".[210]

Although the terms of reference and the outcomes of the review were centred around "collaborative and inclusive leadership" the HSSIB identified a greater need for senior leaders to be trained in the systems-approach to patient safety advocated by the NHS Patient Safety Strategy. Without this, they argued, there was a risk that "a previous more individual focused approach to investigation could persist".[211] The PSA also highlighted the importance of having a joined-up approach to patient safety, and that staff training should be part of a "more rounded" review of standards and accountability that may include a common code of conduct for all health and care professionals.[212]

The Department's submission does not comment on the appropriateness of its interpretation and implementation of the recommendation, merely stating that "investing in leadership and management remains a priority as reflected in the recent NHS Long Term Workforce Plan which reinforced the ambitions of the Messenger review."[213]

The evidence we received indicates that the training developed in response to the recommendation is generally welcome, and that having the same training for social care and health staff was seen by stakeholders as being particularly important. We therefore rate the appropriateness of the Government's interpretation and implementation of this recommendation as 'good'.

205 NHS Norfolk and Waveney ICB (PSN0009); NHS Cornwall and Isles of Scilly ICB (PSN0017); The Royal College of Physicians of Edinburgh (PNS0011); NHS Frimley ICB (PSN0015); The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (PSN0024); NHS Gloucestershire ICB (PSN0020)
206 NHS Gloucestershire ICB (PSN0020)
207 NHS Norfolk and Waveney ICB (PSN0009)
208 The Royal College of Physicians of Edinburgh (PNS0011)
209 NHS Frimley ICB (PSN0015)
210 The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (PSN0024)
211 The Health Services Safety Investigation Body (PSN0004)
212 The Professional Standards Authority (PSN0021)
213 Department for Health and Social Care (PSN0027)

3 Culture of Safety and Whistleblowing

Accepted recommendation	A. Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
"Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns. Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis. Action 1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led." (From the Freedom to Speak Up Review, 2015)	Requires improvement	Good	Requires improvement	Good	Requires improvement
"Primary Care: All principles in this report should apply with necessary adaptations in primary care. Action 19.1: NHS England should include in its contractual terms for general/primary medical services standards for empowering and protecting staff to enable them to raise concerns freely, consistent with these Principles. Action 19.2: NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with this report. Action 19.3: In regulating registered primary care services CQC should have regard to these Principles and the extent to which services comply with them." (From the Freedom to Speak Up Review, 2015)	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

In this section we provide an assessment of the Government's implementation of recommendations in relation to the culture of safety and whistleblowing. Two recommendations were selected for evaluation:

"Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.

Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis.

Action 1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led."

"Primary Care: All principles in this report should apply with necessary adaptations in primary care.

Action 19.1: NHS England should include in its contractual terms for general/primary medical services standards for empowering and protecting staff to enable them to raise concerns freely, consistent with these Principles.

Action 19.2: NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with this report.

Action 19.3: In regulating registered primary care services CQC should have regard to these Principles and the extent to which services comply with them." (From the Freedom to Speak Up Review, 2015)

Recommendation: Culture of safety (accepted by the Government in 2015)

Overall Recommendation Rating and Overview: Requires Improvement

This recommendation seeks to introduce regulatory levers to ensure that senior leaders in NHS organisations understand the culture of safety within their organisations, take steps to improve it, and are transparent about their actions and findings.

The first action is aimed at boards to enable them to move from a "culture of blame" to a culture of understanding and learning, aided by the measurement and monitoring of their culture of safety, and by the publication of their findings. The FTSU review stated that this activity would require "time and resource" from boards.[214] The second action seeks to reward boards which takes action to improve their culture by ensuring this work is recognised by the system regulator as providing evidence that their organisation is well-led.

In July 2015 the Government published a report entitled Learning not Blaming: response to three reports on patient safety,[215] which was a joint response to the FTSU review, the Morecambe Bay Investigation[216] and to the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS'.[217] The Learning not Blaming report highlighted the importance of staff being able to speak up against a "defensive culture more concerned with reputation than with either the truth, or with treating those raising concerns well and fairly" and the steps they were taking to ensure that "honesty and openness is not the heroic exception, but the normal expectation throughout the NHS.".

214 Freedom to Speak Up Report (February 2015), p.12
215 DHSC, Learning not blaming: response to 3 reports on patient safety (July 2015)
216 Morecambe Bay Investigation: Report (March 2015)
217 Public Administration Select Committee Sixth Report of Session 2014–15, Investigating clinical incidents in the NHS, HC 886 March 2015

The report also set out the importance of leadership in promoting a "culture of candour", explaining that responsibility for this lies with boards who "need to be 'problem sensing' rather than 'comfort seeking'". The response set out that the CQC would not be responsible for setting an "open and learning" culture, but for assessing whether organisations are well-led.[218]

The Government set out a series of actions in the Learning not Blaming report to improve speaking up. These included:

- To establish, by December 2015, an Independent National Officer based in the CQC to act as a key leader in a national renewal and reinvigoration of an open and learning NHS culture.[219] The first National Guardian for Speaking Up in the NHS was appointed by the CQC in January 2016.[220]
- The appointment by the Chief Executive of a FTSU guardian in every NHS organisation.
- The development, by the National Guardian and Health Education England (now NHSE), of guidance on local implementation of the FTSU role, training for the FTSU guardian role, and a curriculum that NHS organisations can use to develop training on raising concerns.
- The introduction of a Duty of Candour for organisations. This was formally entered into law 2014[221] (a year before the publication of the FTSU report). The Duty of Candour placed an obligation on provider organisations to be honest with patients and their families when they experience significant harm.[222]

The Learning not Blaming report also set out the Government's plans for ensuring that the FTSU report's principles and actions were implemented across primary care, but indicated that would be published later in 2015. Primary care is covered by the second recommendation which we focus on later in this chapter.

ICSs and ICBs were put on a statutory footing in 2022.[223] NHSE published guidance for ICBs on "how Freedom to Speak Up will support the delivery of those outcomes in terms of worker voice, worker experience and patient safety". The guidance includes a requirement that all ICB staff should have access to FTSU routes by 30 January 2024. The guidance also suggested that ICBs should appoint executive and NEDs for FTSU to provide leadership.[224]

Regarding patient safety more widely, in 2019 NHSE published the NHS Patient Safety Strategy, which set out its new approach to ensuring NHS organisations develop and maintain "effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety development". A key part of the

218 DHSC, Learning not blaming: response to 3 reports on patient safety (July 2015)
219 DHSC, Learning not blaming: response to 3 reports on patient safety (July 2015)
220 The Care Quality Commission "CQC appoints first National Guardian for the freedom to speak up in the NHS", accessed 29 February 2024
221 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 No 2936
222 DHSC, Learning not blaming: response to 3 reports on patient safety (July 2015)
223 Health and Care Act 2022, section 31, Part 1
224 NHSE, 'Integrated care boards, integrated care systems and Freedom to Speak Up', accessed 13 March 2024

NHS Patient Safety Strategy was the introduction of a new national Patient Safety Incident Response Framework (PSIRF).[225] According to Aidan Fowler, NHSE National Director of Patient Safety, as quoted on the NHSE website:

> *"The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen–including the factors which contribute to them"*[226]

The PSIRF sets out how organisations should develop and maintain effective systems and processes for responding to patient safety incidents so they can learn from them and improve patient safety. Its four key aims are:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approached to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight focused on strengthening response system functioning and improvement.[227]

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. To implement the framework, NHS organisations must collect and synthesise patient safety information from a wide variety of sources, and use this to develop a thorough understanding of the following within their organisation:

- patient safety incidents
- ongoing actions they are taking in response to recommendations from patient safety investigations,
- established improvement programmes.[228]

The PSIRF was first introduced in March 2020 when it was tested by 24 early adopters and independently evaluated.[229] Updated PSIRF guidance for organisations on implementing the framework was published in August 2022.[230] Implementation of the PSIRF is mandatory for services provided in the NHS Standard Contract, including acute, ambulance, mental health and community healthcare providers. It is voluntary in primary care.[231]

In 2021 the way patient safety events are recorded in the NHS changed with the introduction of the learn from patient safety events service (LFPSE), which replaces the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (SEIS). The aim of the LFPSE is to record patient safety events, whether they resulted in harm or not, to provide national insights that allow new or under-recognised safety issues

225 NHSE, The NHS Patient Safety Strategy: safer culture, safer systems, safer patients (July 2019)
226 NHSE, 'Patient Safety Incident Response Framework', accessed 16 February 2024
227 NHSE, 'Patient Safety Incident Response Framework', accessed 27 February 2024
228 NHSE Patient Safety Incident Response Framework version 1 (August 2022)
229 NHSE, 'Patient Safety Incident Response Framework', accessed 27 February 2024
230 NHSE, Patient Safety Incident Response Framework version 1 (August 2022)
231 NHSE 'Patient Safety Incident Response Framework', accessed 20 February 2024

to be identified quickly and acted on at a national level, and to support ongoing national and local patient safety improvement activities. The LFPSE was piloted in 2021 and is now a national NHS service for the recording and analysis of patient safety events in healthcare. All NHS organisations are expected to have transitioned to PSIRF and to the LFPSE by "Autumn 2023".[232] We examine how many have achieved this in the section on implementation, below.

We have given an overall rating for the implementation of this recommendation of 'requires improvement'. We conclude that the implementation of the recommendation is underway and significant progress has been made on establishing FTSU guardians and patient safety frameworks. However, there is still considerable variation in the roll out and operation of FTSU guardians, and some trusts have not yet implemented the PSIRF by the Autumn 2023 deadline. It is now nine years since the Government accepted the recommendation which we have taken into account when deciding on our rating, as timeliness of the implementation is important.

Was the recommendation implemented (or on track)? Rating: Requires Improvement

The evidence we received indicated that implementation of the recommendation is underway, but that it is not always consistent across NHS organisations. The ICBs and ICSs which submitted evidence to us described how the recommendation was being implemented within their organisation,[233] supported by new frameworks and guidance put in place by NHSE to support patient safety, particularly the PSIRF.[234] Several stakeholders detailed the actions they were taking to help foster a culture of safety of learning, and how their boards are ensuring progress was made in this area.[235]

Much of the activity described by ICBs and ICSs was relating to the appointment and activities of a FTSU guardian and the ways in which FTSU information is reported to the board. For example, NHS North Central London ICB discussed how their ICB's FTSU guardian is supported by FTSU ambassadors, that the ICB provides additional reminders and support for staff on speaking up, and that "high-level summary of the speaking-up activity is provided annually to the board". One trust contributing to this submission stated that they have 100 FTSU champions, stating that:

> *"Our Audit Committee closely monitored the outputs from our FTSU programme, Whistle blowing and measures on safety culture."*[236]

232 NHSE, 'Patient Safety Incident Response Framework', accessed 27 February 2024; NHSE, 'Learn from patient safety events (LFPSE) service', accessed 20 February 2024

233 NHS Norfolk and Waveney ICB (PSN0009); NHS Cornwall and Isles of Scilly ICB (PSN0017); NHS North East London ICB (PSN0022); NHS Gloucestershire ICB (PSN0020)

234 NHSE, The NHS Patient Safety Strategy: safer culture, safer systems , safer patients (July 2019)

235 NHS North Central London ICB (PSN0014); NHS Norfolk and Waveney ICB (PSN0009); NHS Frimley ICB (PSN0015); NHS Cornwall and Isles of Scilly ICB (PSN0017); NHS Suffolk and North East Essex ICB (PSN0018); NHS Gloucestershire ICB (PSN0020); NHS North East London ICB (PSN0022)

236 NHS North Central London ICB (PSN0014)

NHS Frimley ICB stated:

> *"[…] a [FTSU] system report has been delivered to the board, detailing a number of speak up cases and themes" and "system regulators are part of [their] System Meeting and … have opportunities to raise concerns or highlight good practice."*[237]

Some of the written evidence submissions suggested that the recommendation is not being consistently implemented throughout the country. For example, among the submissions we received from NHS organisations, NHS Suffolk and North East Sussex ICB told us that an "independent Freedom to Speak Up guardian and […] revised freedom to speak up policy" had been implemented in December 2023, and implied the guardian was not yet fully operational and was not yet reporting to their board.[238] Similarly, a trust within NHS North Central London ICB indicated that the PSIRF had not yet been implemented within their organisation.[239] Other stakeholders with a national view also indicated that there is significant variability between organisations in regards to having created a safety culture, both in terms of their implementation of the PSIRF[240] and the implementation of FTSU guardians and policies.[241] The HSSIB stated that in their investigations they had:

> *"[…] encountered significant variability in the safety culture within a range of NHS organisations and their understanding of concepts such as just culture, freedom to speak up, or whistleblowing".*[242]

Professor Graham Martin from the Healthcare Improvement Studies Institute at the University of Cambridge, summarised work he led in 2020 to evaluate various policy interventions that followed the Mid Staffordshire and Morecambe Bay reports, including examining the policy intervention's implementation across the NHS.[243] Professor Martin concluded that he had found "mixed evidence of progress towards a culture of safety and learning in the NHS".[244] With regards to FTSU specifically, Professor Martin indicated that although all organisations are required to have a guardian, the lack of associated funding meant the implementation of the role varied greatly, for example:

- Some guardians received support and protected time from their organisations while others were expected to incorporate this work on top of existing responsibilities.
- Guardians' access to senior decision-makers such as boards varied.
- Variation in the guardians' role in seeking to inculcate culture change and support individuals wishing to speak up.[245]

237 NHS Frimley ICB (PSN0015)
238 NHS Suffolk and North East Essex ICB (PSN0018)
239 NHS North Central London ICB (PSN0014)
240 NHS Gloucestershire ICB (PSN0020)
241 The Health Services Safety Investigation Body (PSN0004), Professor Graham Martin, The Healthcare Improvement Studies Institute (PSN0001)
242 The Health Services Safety Investigation Body (PSN0004)
243 McCarthy, I., Dawson, J. and Martin, G. (2020) Openness in the NHS: a secondary longitudinal analysis of national staff and patient surveys, BMC Health Services Research. 20, 1, 900.
244 Professor Graham Martin, The Healthcare Improvement Studies Institute (PSN0001)
245 Professor Graham Martin, The Healthcare Improvement Studies Institute (PSN0001)

Professor Martin concluded that:

> *"[…] both the Government's approach to introducing the role and organisations' decisions in implementing it were implicated in inconsistent practice".*[246]

The NGO 2023 Annual Report also shows that some organisations report significantly more FTSU cases than others. This, the NGO argues, does not necessarily mean those organisations have more cases but are investing more in FTSU policies. However, the report does provide evidence of a lack of compliance with FTSU requirements in parts: 157 organisations did not submit FTSU case information to the NGO as expected, and four of those were NHS trusts. As a result the NGO writes that they "will be reviewing how we monitor compliance in 2023/24."[247]

We received little evidence to indicate how organisations are supporting staff groups who are likely to face additional barriers to speaking up. An exception was NHS Norfolk and Waveney ICB who said that they had put in place additional measures to provide support for staff groups who may face additional challenges speaking up.[248] A member of NHS staff in our roundtable also highlighted the importance of this, and the potential consequences of failing to do so:

> *"I think one of the barriers to speaking up can also be people from protected characteristics. So if you're somebody who's newly moved here. So I've had experience of that where you're experiencing something negative. Where do I go? I don't know. I don't have the connections etcetera in this organisation. And even if you work in a team that's well-established, but the minority, that can be a barrier in itself. And it means people just leave. And so the problem isn't ever looked at as an issue, because actually the issue is the person who's come in who's not like us. And not like us in whatever you want to describe is a huge thing that we do need to move. So the inclusivity agenda is one that we talk a lot about, but again we need to do much better about how we create a true sense of belonging."*[249]

We also heard from stakeholders about the barriers to implementing culture change that remain within organisations. This included a lack of infrastructure, and accountability of the process to make changes following reviews of cultural problems,[250] a lack of meaningful data on culture collected and reported to regulators,[251] and IT problems causing delays in implementing new patient safety reporting systems.[252]

The charity Patient Safety Learning stated that it was difficult to know which boards were measuring and reporting on patient safety because of a lack of national monitoring and insufficient regulatory sanctions for non-compliance. They concluded that:

246 Professor Graham Martin, The Healthcare Improvement Studies Institute (PSN0001)
247 The National Guardian, "I felt heard for the first time" A summary of speaking up to Freedom to Speak Up Guardians (July 2023)
248 NHS Norfolk and Waveney ICB (PSN0009)
249 Expert Panel roundtable – Group 1
250 British Association of Dermatologists (PSN0003)
251 The Midlands Patient Safety Research Centre (PSN0010)
252 NHS Norfolk and Waveney ICB (PSN0009)

> *"[…] without clear means for identifying and monitoring the progress that individual trusts are making in fostering a culture of safety and learning, and the previously referenced evidence from Staff Survey results and whistleblower accounts suggesting significant elements of blame culture remain, we would contend that this element of the recommendation cannot be said to have been successfully implemented."*[253]

The Patient Safety Commissioner's submission highlighted the importance of having NEDs on boards to support patient safety. However, despite an understanding of patient safety being "critical for this key role" she stated that:

> *"[…] it was surprising to me that patient safety did not feature in induction training for Non-Executive Directors in NHS trusts."*[254]

To counter the lack of such training, the Commissioner stated that she has created informal opportunities for Executives to discuss safety issues.[255]

In our roundtable, we similarly heard about the variability in leadership on boards, particularly among NEDs, who, some argued may not have the skills to challenge reports on patient safety. A member of health and social care staff told us:

> *"[…] non-execs are really variable in what they do and in their level of challenge. And I think that's one of the failings of boards that I've seen up down the country. I've worked with a lot of boards and some are fantastic, they work really hard, they come in to work as and you said, Participant 2, with the right ambition, they want to do it well. However, they've not got the skills. They're very reluctant to challenge. They don't challenge the finances. They don't challenge clinical information. And it is very easy to just reassure yourself constantly that things are fine. And they're not. And that Emperor's new clothes and false reassurance, I think is happening on a daily basis unfortunately."*[256]

In another of our roundtable groups, Dame Linda Pollard, stated:

> *"[…] there's such a variance in the quality of the leadership we've got. And I'm talking board and senior leaders and therefore managers in the system. And they don't have to be big organisations that aren't, you know. Yes, my bar's high. I get that. Not everybody's going to get to that. But the thing is, it's disappointing when you hear and see perhaps leaders not behaving in a manner that is appropriate to create a good working environment for staff, and better patient care. But unfortunately it isn't that yet."*[257]

The PSA expressed concern that severe patient safety failings relating to poor culture continue to be identified, suggesting that existing systems were not working effectively.[258]

253 Patient Safety Learning (PSN0008)
254 Patient Safety Commissioner (PSN0026)
255 Patient Safety Commissioner (PSN0026)
256 Expert Panel roundtable - Group 1
257 Expert Panel roundtable – Group 2
258 Professor Graham Martin, The Healthcare Improvement Studies Institute (PSN0001), The Professional Standards Authority (PSN0021)

The RCM and RCOG stated that:

> *"[…] examples of Shrewsbury and Telford and East Kent are testament to how far some boards are from being able to demonstrate their commitment to creating and maintaining a safe learning culture."*[259]

Professor Martin stated that these high-profile examples provide:

> *"[…] the most visible signs that all is not well in the culture of safety and learning in the NHS and social care", and these "extreme" cases point to problems with openness that "are likely to impact all health and care organisations to varying degrees."*[260]

The CQC's new assessment framework includes a "a quality statement for Learning Culture" and "a quality statement for Freedom to Speak Up". These are assessed at service level and as part of the trust level assessment. This will mean that scores for the FTSU quality statement will be able to directly impact the rating the CQC gives a provider for whether an organisation is "well led".[261] The framework was rolled out in the South region in November 2023, but a timetable for national roll-out has not yet been published.[262] The CQC also stated that they are in discussion with the Department about the introduction of a new regulatory power that would enable them to use enforcement powers against providers who do not act on speaking up concerns, or penalise staff who speak up.[263]

HSSIB gained powers under regulations made under the Health and Social Care Act 2022 to ensure their investigators can access premises, secure evidence, and compel people to speak with us if required.[264] They state that they hope that this will enable them to tackle poor safety cultures within organisations and support patient safety across the NHS.[265]

The Department's submission states that "significant work is underway to implement this recommendation". It refers to the 2019 NHS Patient Safety Strategy, which sets out steps "to support improvement in safety culture alongside a range of other initiatives". The Government's submission highlights the launch of the PSIRF and supporting guidance in 2022 across trusts, which it states "embodies the systems approach" to patient safety, encouraging proactive risk mitigation. The submission also highlights measures already in place, which it states will help "NHS England understand what happens in normal work", and which requires boards to publish Patient Safety Incident Response Plans. The Government's submission also states that early adopters of PSIRF "are reporting a positive impact on their safety cultures".[266]

In their follow-up submission, NHSE provided the latest unverified figures on trust implementation of PSIRF as well as the number of trusts that have transitioned to reporting patient safety incidents on LFPSE. As of February 2024, 132 (63%) of trusts had implemented PSIRF. PSIRF implementation varied by trust type:

259 The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (PSN0024)
260 Professor Graham Martin, The Healthcare Improvement Studies Institute (PSN0001), The Professional Standards Authority (PSN0021)
261 Care Quality Commission (PSN0025)
262 Care Quality Commission, 'How we will roll out our new assessments', accessed 13 February 2024
263 Care Quality Commission (PSN0025)
264 DHSC, The NHSE (Healthcare Safety Investigation Branch) (Revocation, Transitional and Saving Provision) Directions 2023, (October 2023)
265 The Health Services Safety Investigation Body (PSN0004)
266 Department for Health and Social Care (PSN0027)

- Acute: 64% (86/134 trusts)
- Ambulance: 80% (8/10 trusts),
- Community: 79% (11/14 trusts)
- Mental health: 53% (26/48 trusts)
- One combined care sector organisation.[267]

As of 20 February 2024, 70% (145) of trusts had transitioned to reporting on LFPSE, and NHSE anticipate "90% will have transitioned by the end of the financial year".[268]

The Department's submission sets out a range of FTSU related actions that have been taken. This includes:

- the establishment of the independent National Guardian in 2016, which they indicate provides support and leadership to a network of over 1,000 [FTSU] Guardians throughout healthcare in England;
- the introduction in 2018 of "enhanced legal protections" for whistleblowers;
- the new national FTSU policy setting out a minimum standard for FTSU policies across the NHS, which NHS organisations have been asked to adopt by 31 January 2024;
- a self-reflection and planning tool developed by NGO and NHSE to be used by boards to identify gaps that need to be addressed.[269]

With regards to monitoring by boards, the Department's submission sets out that boards should use information from their FTSU guardians to "assess the effectiveness of their speaking up culture, including the culture of safety and learning". Data from the annual NHS Staff Survey can also measure staff perception of culture at a national level. The response also indicates work with the CQC to develop the FTSU quality statement which is part of the CQC's revised single assessment framework.[270]

Overall we conclude that the recommendation to ensure that every organisation involved in providing NHS healthcare actively fosters a culture of safety and learning, in which all staff feel safe to raise concerns, is in progress but has not yet been fully implemented. We are also concerned about the time it has taken the Government to make progress on this recommendation. For example, only half of Mental Health trusts had implemented the PSIRF. We therefore rate the implementation of the recommendation as 'requires improvement'.

Was the implementation of the recommendation effectively funded (or resourced)? Rating: Good

The evidence we received suggested that resource and support has been provided and lack of resource has not been a major barrier to implementation. However there is an issue

267 NHSE (PSN0028)
268 NHSE (PSN0028)
269 Department for Health and Social Care (PSN0027)
270 Department for Health and Social Care (PSN0027)

with the consistency in the deployment of the resources and support. Professor Martin suggested that a lack of absence of additional centrally determined funding for FTSU is "likely to have compromised the success of efforts to foster cultures of safety and learning across the NHS".[271] During our roundtable participants told us about inconsistencies in how the FTSU role is funded and therefore implemented, which could make a difference to how effective the role is. For example, one FTSU guardian in a trust said:

> *"I think that from the Freedom To Speak Up perspective, it's not got funding or it's not at the same, it's not at the same level. So the Banding or the seniority of Freedom To Speak Up guardian in one organisation is not the same in another organisation. Where they report to within an organisation is not the same. The allocated time per size of organisation is not set either. So I think that is very different throughout even acute providers, let alone when you start looking out into what that's going to look like when it goes to primary care. I think it's very different."*[272]

The evidence we received from ICBs and ICSs supported the assertion that there had been no specific funding allocated for the implementation of FTSU and the PSIRF, which they were funding through existing budgets and "business as usual".[273] For example, NHS North East London ICB stated that funding for their FTSU service and the commissioning of the NHS Staff Survey are "both allocated from a central corporate budget" and their FTSU service is managed by an external company at a cost of £142,000 per annum. They added that "there is no funding allocated to reporting to the board on these matters, this work is undertaken as part of business as usual".[274]

NHS Gloucestershire ICB discussed the impact of the lack of funding for the implementation of additional patient safety roles mandated by NHSE. Lack of specific funding for Patient Safety Specialists (PSS)[275] they stated, meant that the ICB had to ask each PSS to cover multiple portfolios. However, they stated that the training for the PSS is now funded by NHSE. Within their ICB the recruitment of Patient Safety Partners[276] also came with "no funding and only guidance of rates of remuneration which can be interpreted locally", which they concluded could lead to variability in their use and effectiveness.[277]

NHS Frimley ICB, and NHS Norfolk and Waveney ICB indicated that innovative and collaborative working by organisations within their systems meant that they were able to ensure patient safety was not compromised by a lack of specific funding.[278] NHS Norfolk and Waveney ICB added that FTSU is "adequately resourced" but is dependent on the efforts of "staff who are themselves sometimes working over and above their contractual hours and duties".[279]

271 Professor Graham Martin, The Healthcare Improvement Studies Institute (PSN0001)
272 Expert Panel roundtable – Group 1
273 NHS Frimley ICB (PSN0015), NHS Norfolk and Waveney ICB (PSN0009), NHS North East London ICB (PSN0022), NHS Gloucestershire ICB (PSN0020)
274 NHS North East London ICB (PSN0022)
275 NHSE, 'Patient Safety Specialists', accessed 19 February 2024
276 NHSE, The NHS Patient Safety Strategy: safer culture, safer systems, safer patients , July 2019
277 NHS Gloucestershire ICB (PSN0020)
278 NHS Frimley ICB (PSN0015); NHS Norfolk and Waveney ICB (PSN0009)
279 NHS Norfolk and Waveney ICB (PSN0009)

The Department's submission only referred to the National Guardian's Office under this question, stating:

> *"The NGO [National Guardian's Office] is staffed by 16 people with an annual budget of £1.58m in 2023/24".*[280]

In their follow-up submission, the Department confirmed that trusts have received no funding to implement PSIRF, and that implementation of the PSIRF is being supported through "the Patient Safety Collaboratives hosted by the 15 Health Innovation Networks (HINs) and through direct support from the national patient safety team." According to the Health Innovation Network, Patient Safety Collaboratives are "funded and nationally coordinated by NHS England".[281]

We conclude that the funding aspect for the implementation of this recommendation is 'good'. This is based on the evidence we received that resource and support has been provided and lack of resource has not been a barrier to implementation. However, we note concerns from some that parts of the funding comes from organisational/ICB budgets, or has to be factored in to "business as usual". Where organisations differ in the demands on their budgets, this could result in differences in the amount of funds available for FTSU activities and thus to variable implementation.

Did the implementation of the recommendation achieve positive impacts for patients and people in receipt of social care? Rating: Requires improvement

We received little specific evidence regarding whether the implementation of the recommendation has had a positive impact on patients and people in receipt of social care, and some stakeholders suggested that this was considered difficult to measure.[282] However, as recognised by the Royal Pharmaceutical Society, implicit in the recommendation is that an improved culture of safety, including openness and speaking up, will benefit patients and people in receipt of care.[283]

We were concerned by what was suggested in some of the evidence we received, both from stakeholders and from participants in our roundtable, that health and care staff do not yet all feel able to raise concerns.[284] The British Association of Dermatologists said that staff were not using FTSU because of concerns about confidentiality. They also stated that problems with safety culture in organisations were causing staff to leave which meant some dermatology departments did not have sufficient staff, which negatively impacts patient outcomes.[285] The Royal College of Physicians of Edinburgh said staff remained fearful and concluded:

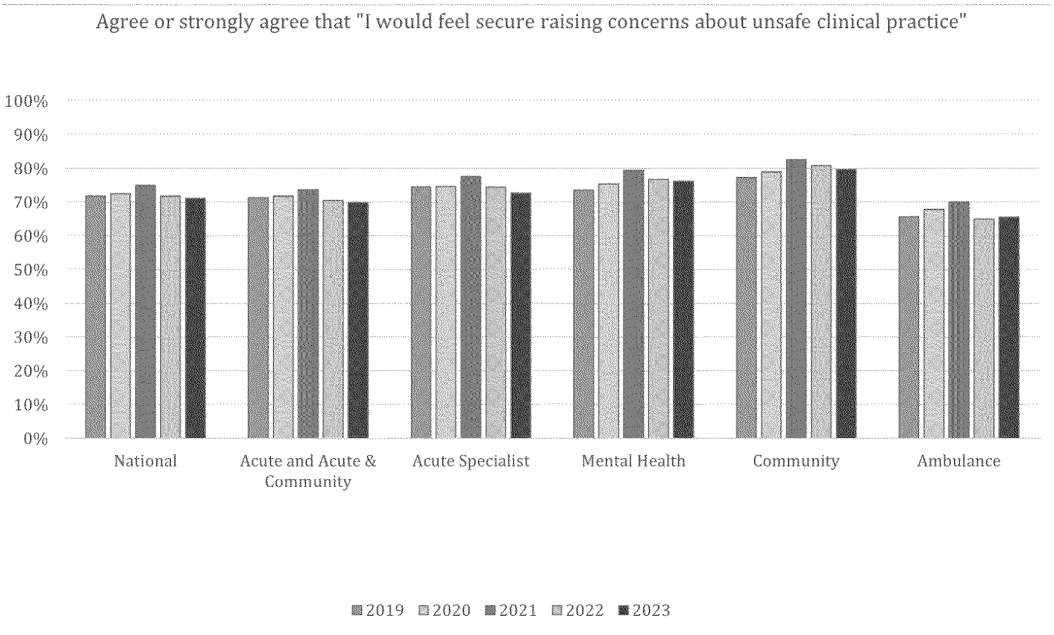
> *"[..] we are a long way from all who raise issues through whatever route feeling that their issue has been listened to considered and replied to."*[286]

280 Department for Health and Social Care (PSN0027)
281 Health Innovation Network, 'Patient Safety Collaboratives', accessed 27 February 2024
282 Professor Graham Martin, The Healthcare Improvement Studies Institute (PSN0001); The Midlands Patient Safety Research Centre (PSN0010)
283 The Royal Pharmaceutical Society (PSN0019)
284 The Royal College of Physicians of Edinburgh (PNS0011); The Medical Protection Society (PSN0013); Patient Safety Learning (PSN0008)
285 British Association of Dermatologists (PSN0003)
286 The Royal College of Physicians of Edinburgh (PNS0011)

Professor Martin stated that improvements in staff perceptions in relation to patient safety since the mid-2010s, "have attenuated or reversed".[287]

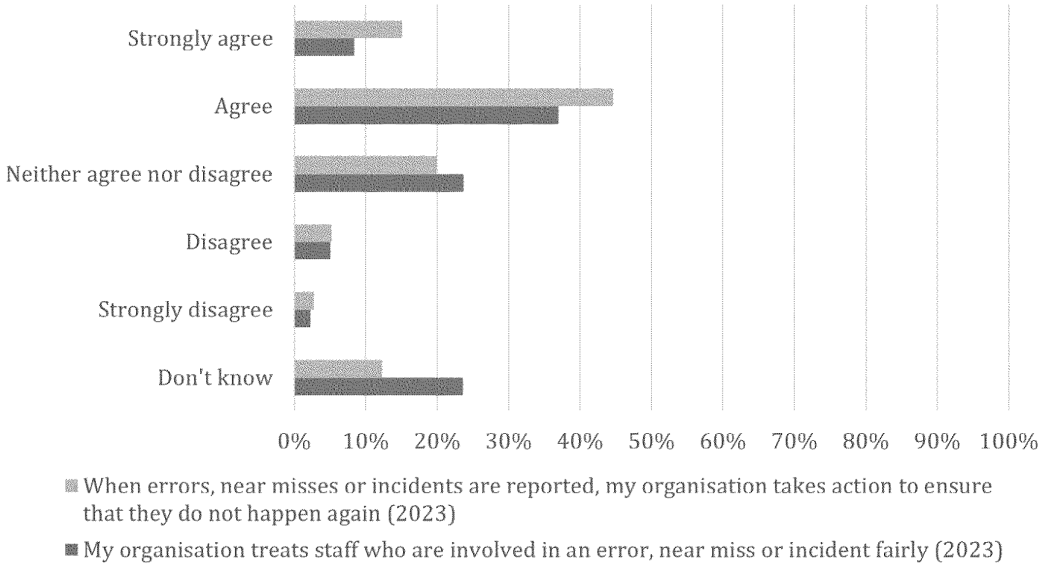
The views and experiences of NHS trust staff on matters including speaking up and patient safety are gathered annually through the NHS Staff Survey.[288] Results from the 2023 survey were published on 7 March 2024.[289] These showed that, nationally, only 71% of staff agreed or strongly agreed that they felt safe raising concerns. Worryingly, this is the lowest figure in five years and a 4% decrease since 2021 (see Figure 1).[290] It is also concerning that only 45% of trust staff in 2023 agreed or strongly agreed that their organisation treats staff who are involved in an error, near miss or incident fairly; and only 60% of staff agreed or strongly agreed that when errors, near misses or incidents are reported, their organisation takes action to ensure it does not happen again (see Figure 2).[291]

Figure 1: The percentage of NHS trust staff from 2019 to 2023 who agreed or strongly agreed with the question "I would feel secure raising concerns about unsafe clinical practice". Data from the NHS Staff Survey interactive dashboard. [292]



287 Professor Graham Martin, The Healthcare Improvement Studies Institute (PSN0001)
288 NHS Staff Survey, 'Working together to improve NHS staff experiences', accessed 4 March 2024
289 NHSE, NHS Staff Survey 2023 – National Results, (March 2023)
290 NHSE, NHS Staff Survey 2023 – National Results, (March 2023)
291 NHS Staff Survey, 'NHS Staff Survey dashboard', accessed 7 March 2024
292 NHS Staff Survey, 'NHS Staff Survey dashboard', accessed 7 March 2024

Figure 2: Responses to two patient safety questions in the 2023 NHS Staff Survey. Data from the NHS Staff Survey interactive dashboard [293]



The NHS Staff Survey responses differ considerably by trust type. Staff at Community trusts gave the most positive responses to questions about speaking up and patient safety, whereas staff in Ambulance trusts were the most negative. For example, over two thirds (68%) of Community trust staff agreed or strongly agreed that their organisation takes action in response to patient safety incident reports and four fifths (80%) felt secure raising concerns about unsafe clinical practice. By contrast, in Ambulance trusts under half (48%) of staff agreed their organisation takes action in response to patient safety incident reports, and only two thirds (66%) felt secure raising concerns about clinical practice.[294]

Sands and Tommy's Joint Policy Unit told us that "reports show difficulty for staff to escalate concerns, with HSSIB finding 'rigid processes' for escalation in some units which disempower staff from seeking support".[295] The Medical Protection Society similarly said that doctors' fear of being investigated for errors in patient care was growing due to the increased pressures on the NHS, and that this was made worse by the culture within the NHS being focused on blame, punishment and even criminalisation, rather than on learning from mistakes.[296]

In our roundtable, an NHS whistleblower said that although he himself had not worked within the NHS for several years, he was regularly contacted by NHS staff who told him that staff who raise concerns are "targeted" by senior managers and FTSU was not sufficient to address this "ingrained issue":

> *"Really, I would have thought the ideal would be for executives and boards to see whistleblowers as their guard dogs or their canary in the coal mine. Yet I think whistleblowers continue to be seen as traitors, as quislings, as people who have broken the NHS omerta, who are a reputational threat. And I see people*

293 NHS Staff Survey, 'NHS Staff Survey dashboard', accessed 7 March 2024
294 NHS Staff Survey, 'NHS Staff Survey dashboard', accessed 7 March 2024
295 Sands and Tommy's Joint Policy Unit (PSN0023)
296 The Medical Protection Society (PSN0013)

> *continuing to be reported to the regulators in revenge for whistleblowing. And I don't see that the sort of atmosphere in which whistleblowers operate has changed at all. So I don't think the government has met it promises there."*[297]

He went on to explain that senior managers were too concerned with reputation management to listen to staff who raise serious concerns and act upon this:

> *"You have senior executives who are surrounded by comms teams and so on, who are dedicated to putting out positive news and putting a positive spin on everything. And then, of course, the whistleblower pops up and gives a very contrary narrative to that. And so suddenly all the good intentions go out of the window. When I was taken down by my old trust, they had not long before signed a board statement saying, "we promise no whistleblower will suffer any detriment or dismissal" and of course, that went straight out of the window when I popped up saying, "we're making the same mistakes here that we made with the [previous] scandal". So I think basically reputation management trumps everything.*[298]

A FTSU guardian in the same roundtable agreed that staff lacked confidence in the process of dealing with concerns and feared reprisals. In her view, this demonstrated there was not yet a positive culture, which posed a major problem in addressing patient safety issues:

> *"The biggest stumbling block becomes, "well what happens next? So if I speak up about concerning behaviour, what will the trust do about that? What will the system do about that? What will the NHS as a whole do"*[299]

Another FTSU guardian in the same group agreed that although staff in her own organisation did now feel more confident to speak up, this was not necessarily the case in other organisations, and although having FTSU guardians was important, it had not solved the problem of staff finding it difficult to raise concerns:

> *"I personally think from my experience over the last kind of six years being within this role, I do think it's improved. Staff confidence and having someone impartial to speak to, do I think it's answered the problem? And do I think that we're there? No way. No, I don't. But, from a personal experience, I feel like we're going in the right direction. But you know, I definitely think that would vary significantly depending on organisation still."*[300]

Some of the stakeholders we received evidence from indicated that the current monitoring and evaluation of patient safety initiatives was insufficient. For example Patient Safety Learning wrote that although guidance to help NHS trusts foster a patient safety culture has been issued, in their view "there appears to be no clear system for ensuring that this is implemented across the NHS, and no public plans to monitor and evaluate the success of this."[301] The Midlands Patient Safety Research Centre highlighted that the existing metrics used by organisations to report to regulators are those which can easily be measured numerically, such as number of incidents of falls, length of stay, or re-admission rates. They

297 Expert Panel Roundtable - Group 1
298 Expert Panel Roundtable - Group 1
299 Expert Panel roundtable – Group 1
300 Expert Panel roundtable – Group 1
301 Patient Safety Learning (PSN0008)

argued that these metrics are not sufficient to enable the culture of their organisation to be assessed by regulators, without insights from "soft intelligence" and staff outcomes being included in reports to regulators.[302] The British Association of Dermatologists similarly felt that patient safety metrics lacked information on staff outcomes such as staff sickness rates.[303] NHS Gloucestershire ICB indicated that, although support networks have been set up for FTSU guardians, there is no evidence yet about how effective they are.[304]

The PSA felt that insufficient attention was paid to how the organisational duty of candour intersects with the individual duty of candour of regulated health and care professionals.[305] Similarly, in the roundtable we heard that healthcare staff can sometimes have conflicting loyalties that make it challenging for them to speak up.[306]

The Department's submission stated: "There are some positive signs of progress but there is more work to be done to make this recommendation a reality across the NHS".[307]

We have rated the impact that the implementation of this recommendation has had on patients and people in receipt of social care as 'requires improvement'. The latest NHS staff survey shows that the proportion of trust staff who feel safe to speak up has declined and is at a five-year low. Our rating reflects evidence that a significant proportion of staff do not feel safe to speak up and do not feel that their organisation takes action to address patient safety incidents, and also the Department's own admission that more work is required to implement the recommendation.

Was the recommendation interpreted appropriately? Rating: Good

The evidence we received generally welcomed the efforts to improve patient safety by implementing this recommendation. There were indications however that they did not go far enough to address the very significant issues that exist within health and care organisations due to insufficient funding, lack of consideration of how the recommendations intersect with existing guidance and regulation, and an over-emphasis on issuing guidance without monitoring and evaluating impacts.[308]

Professor Martin stated that the Government's interpretation of the recommendation appeared "considered and reasonable".[309] The PSA similarly indicated that the establishment of FTSU guardians in trusts and the National Guardian were a "positive development", but that this had not been sufficient to prevent the regular emergence of patient safety issues connected to poor culture. The PSA were also "fully supportive" of the HSSIB "safe spaces approach to safety investigations" and the PSIRF, describing both as "significant national initiatives" to improve patient safety. However, they believed that not enough consideration has been given to how these approaches "are meant to intersect with arrangements for individual accountability, and particularly professional regulation,

302 The Midlands Patient Safety Research Centre (PSN0010)
303 British Association of Dermatologists (PSN0003)
304 NHS Gloucestershire ICB (PSN0020)
305 The Professional Standards Authority (PSN0021)
306 Expert Panel Roundtable – Group 2
307 Department for Health and Social Care (PSN0027)
308 The Professional Standards Authority (PSN0021); Patient Safety Learning (PSN0008); The Health Services Safety Investigation Body (PSN0004); Professor Graham Martin, The Healthcare Improvement Studies Institute (PSN0001)
309 Professor Graham Martin, The Healthcare Improvement Studies Institute (PSN0001)

which relies on information being available and shared about the actions of individuals." They concluded that the approaches potentially put up "barriers to the free-flow of safety-critical information".[310]

The HSSIB were "hopeful" that NHSE's Patient Safety Strategy will have a positive impact on safety culture within NHS organisations, but warned that policies and guidance are not evidence of a safe culture and current implementation frameworks and regulations from local and national bodies are fragmented, overlapping and conflicting.[311]

Patient Safety Learning stated that although NHSE has introduced new good practice resources aimed to help trusts foster a patient safety culture, there is insufficient focus on ensuring implementation and measuring outcomes. They stated that "this may be something that is being considered by the NHSE Safety Culture Implementation Group, though there is no indication of this in the public domain that we are aware of." They also questioned whether the CQC inspection processes result in subsequent improvement in performance.[312]

The Department's submission indicated that the interpretation and implementation of the recommendation was appropriate, however they acknowledged that "work continues to further ensure the NHS embraces a culture of safety and learning, in which all staff feel safe to raise concerns".[313]

Based on the evidence we received, we have rated the appropriateness of the interpretation of this recommendation by the Government as 'good'.

Recommendation: Culture of safety in primary care (accepted by the Government in 2015)

Overall Recommendation Rating and Overview: Requires improvement

This recommendation applies specifically to primary care. During the FTSU review, the review team conducted various surveys of healthcare professionals. The subsequent report concluded that professionals in primary care were more likely to take complaints outside of their own organisation such as a professional body or regulator.[314]

An updated FTSU "guide and improvement tool" alongside an updated national FTSU policy was published in in June 2022. The FTSU policy states that:

> *"All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure all matters raised are captured and considered appropriately."*[315]

310 The Professional Standards Authority (PSN0021)
311 The Health Services Safety Investigation Body (PSN0004)
312 Patient Safety Learning (PSN0008)
313 Department for Health and Social Care (PSN0027)
314 Freedom to Speak Up Report (February 2015)
315 NHSE, Freedom to Speak Up policy for the NHS (June 2022)

According to the "reflection and planning tool" document, the purpose of it is to help senior leads for FTSU within an organisation to identify their own strengths and strengths in their leadership team and their organisation, as well as identifying any gaps that need work. The tool stipulates that the senior lead for FTSU "should take responsibility" for completing the tool "at least every two years". The tool document sets out that:

> *"Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements."*[316]

According to the NHSE website's FTSU guidance for ICBs and ICSs, considering how FTSU will support the delivery of "worker voice, worker experience and patient safety" is important. Furthermore, the website states that ICBs should consider routes for primary care workers across their ICSs having access to routes for "speaking up", including a FTSU guardian who is registered and trained by the NGO. This guidance concludes:

> *"Based on our ongoing work with primary care and ICBs referenced above, NHS England and the National Guardian's Office plan to share further information by 31 March 2024 about the precise expectations of ICBs in regard to Freedom to Speak Up for primary care workers and across their system."*[317]

The General Practice Staff Survey was piloted in half of ICBs in 2023 to gather the views and experiences of general practice staff, including on patient safety and speaking up, however at the time of writing we have not had sight of the results.[318]

In the evidence we received, some submissions referred to the NHS Patient Safety Strategy[319] and the PSIRF[320] in response to whether this recommendation has been implemented. According to the updated PSIRF document published in August 2022:

> *"Primary care providers may wish to adopt this framework, but it is not a requirement. Primary care providers that wish to adopt this version of the framework should work with their integrated care board (ICB) to do so. Further exploration is required to ensure successful implementation of the PSIRF approaches within primary care. The National Patient Safety Team will work with a small number of primary care early adopters to explore how the PSIRF can be adapted to this sector."*[321]

The NHS Patient Safety Strategy reinforces similar messages as the FTSU report, including the importance of "psychological safety" for staff, and a culture where staff at a "group level" know they can speak up when error has been made or where they have a safety concern, and will be treated "compassionately and fairly" when doing so.[322] The most recent report analysing the annual survey of FTSU guardians, the NGO concludes:

316 NHSE and the national Guardians Office, Freedom to Speak Up – A reflection and planning tool (June 2022)
317 NHSE, 'Integrated care boards, integrated care systems and Freedom to Speak Up', accessed 13 March 2024
318 NHS Staff Survey 'NHS Staff Survey 2023 Key Messages', accessed 4 March 2024
319 NHSE and NHSE Improvement, The NHS Patient Safety Strategy - Safer culture, safer systems, safer patients (July 2019)
320 NHSE, Patient Safety Incident Response Framework (August 2022)
321 NHSE, Patient Safety Incident Response Framework (August 2022)
322 NHSE and NHSE Improvement, The NHS Patient Safety Strategy - Safer culture, safer systems, safer patients (July 2019)

> *"Fourteen per cent of Freedom to Speak Up guardians trained and registered with the National Guardian's Office support primary medical services (PMS). In comparison, Freedom to Speak Up guardians that support PMS accounted for five per cent of those participating in our survey. Even where guardians are in place in primary medical services, levels of speaking up to them remains low."*[323]

Good progress has been made in rolling out improved guidance with regards to patient safety more widely, and there is some evidence of ICBs implementing processes to ensure staff are able to speak up. However, the evidence we have seen does not indicate to us that success is evenly distributed across the country. Primary care professionals are less likely to engage with a FTSU guardian or another internal route to raise concerns, and clear expectations for how the FTSU policy applies to primary care have not been published. As we outline below, stakeholders expressed concerns about how to properly implement FTSU in primary care where the operating model often means staff work in smaller organisations or teams. Overall, our rating of the implementation of this recommendation is that it 'requires improvement'.

Was the recommendation implemented (or on track)? Rating: Requires improvement

Many stakeholders supported the principle of implementing this recommendation in the context of primary care but recognised the challenge in doing so. The PSA stated:

> *"The Government accepted all the recommendations from the 2015 Freedom to Speak Up Review in full and took steps soon afterwards to establish freedom to speak up guardians in individual trusts as well as the role of National Guardian hosted by the Care Quality Commission. This was a positive development, but the regular emergence of patient safety issues connected to poor culture shows that challenges remain."*[324]

The majority of NHS organisations we heard from acknowledged the forthcoming Patient Safety Strategy for primary care, including the British Dental Association which describe it as an "important recent development".[325] The CQC stated that when they assess GP practices, they look at whether staff feel able to raise concerns, whether the practice encourages openness and honesty, and whether staff have access to a FTSU guardian. The CQC provides guidance to ensure GP practices understand how this assessment is carried out, and what is considered best practice. Furthermore, the CQC stated:

> *"[…] we have introduced a quality statement on Freedom to Speak Up as part of the assessment framework we will be using under our new regulatory approach. When assessing primary care services against this quality statement, we'll look at evidence related to feedback from staff and leaders and processes. The quality statement sits under the Well-led key question and will be considered as part of our assessments of all primary care providers."*[326]

323 The National Guardians Office, Listening to Guardians – Freedom to Speak Up Guardian Survey 2023 (July 2023)
324 The Professional Standards Authority (PSN0021)
325 British Dental Association (PSN0016)
326 Care Quality Commission (PSN0025)

NHS Norfolk and Waveney ICB stated that the Patient Safety Strategy has provided "guidance and structure regarding the implementation of new safety systems". They explained that they were putting into practice the four core aims of the PSIRF. They pointed out that the PSIRF was not yet mandated for primary care but had been rolled out on a trial basis in the ICB. Furthermore, they stated that the ICB continued to "support" FTSU and that it the process for raising concerns had been made clear to primary care professionals.[327] NHS North Central London ICB stated the ICB has "provision in place to support staff members in General Practice–should they wish to have a confidential 'speak-up' conversation".[328] NHS Frimley ICB stated that they have:

> *"[…] supported Primary Care to have robust FTSU policies and currently the CQC have not identified any areas for improvement on this metric."*[329]

NHS Cornwall and Isles of Scilly ICB were early adopters of the PSIRF, and stated that their ICS now has a system patient safety forum each month for health and social care providers to enable "rapid mitigation of risk, shared learning and improved relationships".[330] NHS Suffolk and North East Essex ICB stated that their own FTSU policy is based on the NHS national framework, and that their local application of it had been designed to be used by all ICB staff, as well as its constituent Alliances and primary care network (PCN).[331] NHS North East London ICB similarly stated that their Patient Safety team had been "working closely with providers" to embed the Patient Safety Strategy, particularly, they stated, in establishing the PSIRF.[332]

NHS Gloucestershire ICB however raised concerns about the forthcoming primary care specific Patient Safety Strategy, stating:

> *"An early draft seen by the ICB suggests that the same contractual mechanisms applied in secondary care will not apply in primary; this is disappointing and is a missed opportunity. While many practices are forward looking and foster a positive and supportive culture, 'safety' in primary care often operates at a local practice level. Our opinion is that contractual mechanisms and specific funding could have expanded this to system level resulting in better integration with safety systems in secondary care."*[333]

During our roundtable, Sam Foster, Executive Director for Professional Practice at the Nursing and Midwifery Council, similarly pointed to the many organisational structures of primary care providers and the varying practice in regard to patient safety learning as an issue in implementing this recommendation:

> *"There are some excellent federations and groupings. But equally there's some really poor governance and people that don't even report patient safety incidents, let alone learn and discuss them. And right through to some excellent examples of learning and good safety environments, culture, good leadership."*[334]

327 NHS Norfolk and Waveney ICB (PSN0009)
328 NHS North Central London ICB (PSN0014)
329 NHS Frimley ICB (PSN0015)
330 NHS Cornwall and Isles of Scilly ICB (PSN0017)
331 NHS Suffolk and North East Essex ICB (PSN0018)
332 NHS North East London ICB (PSN0022)
333 NHS Gloucestershire ICB (PSN0020)
334 Expert Panel Roundtable – Group 2

In another of our roundtable groups, a participant identified the specific challenge for primary care:

> *"I think because it's so many different organisations, every system will be different. So you've got practices that may only have a couple of GPs and a few receptionists all the way through to a practice where there's 30 GPs and goodness knows how many staff. So it's just completely different. And we're now getting practices where there's actually boards, which just seems alien to me because it used to be, you know, six partners would be in charge and that was how it was. And now suddenly we've got boards and Chief Operating people. So every practice is going to be very different. And I don't know how you would ensure each practice has a safe system in place. Really. And I guess that comes down to the ICB. They have a glorious job."*[335]

Another participant stated:

> *"I think GP practices are almost outliers in terms of culture, because they're run as businesses; you can't really tell them what to do. You can guide them as to what they can and can't do. You can tell them they've got to have this policy and they've got to have X policy, and everyone's got to have an induction, and everyone should be X, Y and Z, but actually that doesn't happen. They'll get the policy out when the CQC turn up, but actually what they're doing is very different. And I've seen that from the inside, that's the problem with GP practices, unfortunately."*[336]

Other stakeholders identified significant gaps in relation to embedding learning within primary care, especially when taking into account dentistry and community pharmacy. For example, HSSIB noted challenges in engaging with primary care providers, including lack of incident reporting data and refusals to engage with investigations. They argued that this limits the learning from patient safety events and in turn reinforces negative perceptions and cultures around safety in primary care.[337] The British Dental Association (BDA) noted that whilst there have been attempts to set up a system in the primary care/general dental practice sphere, "these attempts have so far not borne fruit". The BDA argued that the structures in general dental practice are not conducive to such processes in the same way as they might be in bigger entities such as hospital trusts.[338]

The Government's submission argued that contractual terms for primary medical services include protections for staff wishing to raise concerns, and the submissions sets out the contractual terms for different primary care professions. The Government's submission also highlighted the ongoing work of the NGO working with primary care providers to understand how the FTSU guardian role could be introduced in primary care and integrated settings.[339]

We agree there has been some encouraging progress in facilitating a culture where people feel empowered and able to speak up in primary care. However, specific guidance of expectations of roll out in primary care has been delayed and despite the recommendation

335 Expert Panel Roundtable – Group 1
336 Expert Panel Roundtable – Group 3
337 The Health Services Safety Investigation Body (PSN0004)
338 British Dental Association (PSN0016)
339 Department for Health and Social Care (PSN0027)

being explicit that the principles should be part of the contract for primary care services, they are not. There is still work to be done before this recommendation has been fully implemented. Therefore, we conclude that in respect to whether the recommendation has been, or is on track to be, implemented 'requires improvement'.

Was the implementation of the recommendation effectively funded (or resourced)? The rating: Good

Many of the NHS organisations which we heard from described the funding in place as limited. For example, NHS Frimley ICB highlight they have a nominated board member as the FTSU guardian, but that implementation is challenging due to the lack of resource. They further added that they are currently working to identify solutions to using current resources.[340] NHS Gloucestershire ICB argued that contractual mechanisms and specific funding could have expanded the contractual mechanisms in secondary care to primary care system level resulting in better integration with safety systems in secondary care.[341]

NHS Gloucestershire ICB argued that contractual mechanisms and specific funding could have expanded the contractual mechanisms in secondary care to primary care system level resulting in better integration with safety systems in secondary care.[342]

In their response the Government noted that whilst there was an initial allocation of funding for the NGO to explore the roll out of Freedom to Speak Up in primary care, there has not been any additional funding to support the roll out and to address the particular challenges in this area around speaking up routes and access to guardians.[343] However, we did not see any evidence pointing to issues in regards to funding and seeing as the FTSU scheme is up and running we conclude that funding and resource provisions are 'good'.

Did the implementation of the recommendation achieve positive impacts for patients and people in receipt of social care? Rating: Requires improvement

The BDA concluded they were not aware of meaningful improvement in measurable outcomes for patients. They stated that, hypothetically should a staff member be acting or providing care incorrectly, and that behaviour stop then "that must be a benefit to patients". They stated that dental patients would benefit in theory, but that "it is unclear there has been a significant improvement" as a direct result of the recommendation being implemented.[344] Addressing both recommendations under 'culture' together, the College of Paramedics similarly noted that patient safety would improve by reporting concerns and learning from incidents.[345]

In their response, the Government highlighted that there are 135 trained and registered primary care guardians on the NGO directory, supporting over 400 primary care services.

340 NHS Frimley ICB (PSN0015)
341 NHS Gloucestershire ICB (PSN0020)
342 NHS Gloucestershire ICB (PSN0020)
343 Department for Health and Social Care (PSN0027)
344 British Dental Association (PSN0016)
345 The College of Paramedics (PSN0007)

They stated that despite national guidance, primary care organisations are less likely to submit data on FTSU cases, and noted that the NGO is aiming to improve data reporting compliance across all sectors including primary care during 2023/24.[346]

In summary, evidence indicates that there are some issues regarding measuring the impact of this recommendation. However, we agree that any efforts to improve reporting, and the following up on patient safety concerns or incidents, are likely to deliver positive impacts for patients and people in receipt of social care. We conclude that the progress in this respect 'requires improvement', due to the uneven application and take up amongst primary care organisations. We welcome the announcement of upcoming guidance and a new framework. Whilst we recognise the benefits implementation of this recommendation will bring to patients we remain some way off the realisation of its potential and the effective measurement of its impact.

Was the recommendation interpreted appropriately? Rating: Requires improvement

It may be too early to consider whether the Government's implementation of this recommendation constitutes an appropriate interpretation. As we discussed earlier in this chapter, some guidance and frameworks are in place but other aspects such as the FTSU primary specific "expectations" are forthcoming.

NHS Norfolk and Waveney ICB stated that the ICB can only "advise" in cases where primary care staff can raise concerns.[347] A participant at our roundtable argued that in primary care, although FTSU guardians are in place, there is uncertainty in the process following a disclosure:

> *"So, everywhere does have a Freedom to Speak Up guardian, somebody to go to and that's great, yes, you can raise your concerns, the problem, whatever's happening. But it's then anything actually happening subsequent to that. So yes, they can be raised to the board, they can be raised to the partners, it can be raised, but then actually anything changing around that doesn't seem to, there isn't much change, is how it feels. And then the people who do then report those concerns in, as [another participant] said, are essentially - they might get sidelined, they may not then be taken into managerial positions because they're seen as being troublemakers. So that's a recurring theme. And I've heard of that from several colleagues that I've worked with.*[348]

The Department and NHSE submission stated that the interpretation and implementation of the recommendation was appropriate, but note that work continues to deliver Freedom to Speak Up within primary care services.[349]

Based on the limited information available to us, we conclude that the rating in respect of interpretation of this recommendation 'requires improvement'.

346 Department for Health and Social Care (PSN0027)
347 NHS Norfolk and Waveney ICB (PSN0009)
348 Expert Panel roundtable – Group 1
349 Department for Health and Social Care (PSN0027)

Annex A: Anchor statements for CQC-style ratings of recommendations

Rating	Has the recommendation been implemented? Or (in the case of a recommendation whose deadline has not yet been reached) Is the recommendation on track to be implemented?	Has there been specific and adequate funding to enable the recommendation to be implemented?	Has there been a positive impact on patients and people in receipt of social care as a result of the recommendation being implemented?	Was the Government's interpretation and implementation of the recommendation appropriate?
Outstanding	The recommendation was fully implemented / there is a high degree of confidence that the recommendation will be implemented	The implementation of the recommendation was funded without shortfall	Stakeholders agree that the impact was positive	Evidence confirms the appropriateness of the interpretation and implementation of the commitment
Good	The recommendation was implemented but there were some minor gaps, or it is likely to be implemented within a short time after the deadline date/ it is likely that the recommendation will be implemented, but some outstanding issues will need to be addressed to ensure that is the case	The implementation of the recommendation was effectively funded, with minor shortfalls	The majority of stakeholders agree that the impact was positive	Evidence suggests the interpretation and implementation of the commitment was appropriate overall, with some caveats
Requires improvement	The recommendation has not been implemented and substantive additional steps will need to be taken to ensure it is implemented within a reasonable time/ the recommendation will only be implemented if substantive additional steps are taken	The implementation of the recommendation was ineffectively funded	A minority of stakeholders agree that the impact was positive	Evidence suggests the interpretation and implementation of the commitment needs to be modified
Inadequate	The recommendation has not been implemented and very significant additional steps will need to be taken to ensure that it is met within a reasonable time/ the recommendation will only be implemented if very significant additional steps are taken	Significant funding shortfalls prevented the recommendation from being implemented	Most stakeholders did not agree that there was a positive impact	Evidence suggests the interpretation and implementation of the commitment was not appropriate

Annex B: Published written submissions

The following written submissions were received and can be viewed on the inquiry publications page of the Committee's website.

(1) Professor Graham Martin, The Healthcare Improvement Studies Institute, University of Cambridge (PSN0001)

(2) Professor Marian Knight, MBRRACE-UK (PSN0002)

(3) British Association of Dermatologists (PSN0003)

(4) Health Services Safety Investigations Body (PSN0004)

(5) The Royal College of Pathologists (PSN0005)

(6) Dementia UK (PSN0006)

(7) College of Paramedics (PSN0007)

(8) Patient Safety Learning (PSN0008)

(9) NHS Norfolk and Waveney ICB (PSN0009)

(10) Professor Alice Turner, Professor Richard Lilford and Professor Shakila Thangaratinam, Midlands Patient Safety Research Centre at the University of Birmingham (PSN0010)

(11) The Royal College of Physicians of Edinburgh (PSN0011)

(12) Medical Protection Society (PSN0013)

(13) NHS North Central London Integrated Care Board (PSN0014)

(14) NHS Frimley ICB (PSN0015)

(15) British Dental Association (PSN0016)

(16) NHS Cornwall and Isles of Scilly ICB (PSN0017)

(17) NHS Suffolk and North East Essex Integrated Care Board (PSN0018)

(18) Royal Pharmaceutical Society (PSN0019)

(19) NHS Gloucestershire Integrated Care Board (PSN0020)

(20) Professional Standards Authority for Health and Social Care (PSN0021)

(21) NHS North East London ICB (PSN0022)

(22) Sands and Tommy's Joint Policy Unit (PSN0023)

(23) The Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists (PSN0024)

(24) Care Quality Commission (PSN0025)

(25) Office of the Patient Safety Commissioner (PSN0026)

(26) Department of Health and Social Care (PSN0027)

(27) Supplementary evidence provided by NHS England (PSN0028)

(28) Supplementary evidence provided by the Department of Health and Social Care (PSN0029)

Annex C: Transcripts

Roundtable with health and social care professionals:

(29) Group 1 (PSN0030)

Roundtable with professionals who had led or been involved in public inquiries or reviews which had made patient safety related recommendations. Members of this group have agreed to be identified within our report:

(30) Group 2 (PSN0031)

Roundtable with patients and people in receipt of social care, or their representatives:

(31) Group 3 (PSN0033)