House of Commons

Health and Social Care Committee

Expert Panel: Evaluation on meeting patient safety recommendations: Government Response

Second Special Report of Session 2024–25 HC 617

Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and Social Care and its associated public bodies.

Current membership

Layla Moran (Liberal Democrat; Oxford West and Abingdon) (Chair)

Danny Beales (Labour; Uxbridge and South Ruislip)

Ben Coleman (Labour; Chelsea and Fulham)

Dr Beccy Cooper (Labour; Worthing West)

Deirdre Costigan (Labour; Ealing Southall)

Jen Craft (Labour; Thurrock)

Josh Fenton-Glynn (Labour; Calder Valley)

Andrew George (Liberal Democrat; St Ives)

Paulette Hamilton (Labour; Birmingham Erdington)

Joe Robertson (Conservative; Isle of Wight East)

Gregory Stafford (Conservative; Farnham and Bordon)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No. 152. These are available on the internet via www.parliament.uk.

Publication

This Report, together with formal minutes relating to the report, was Ordered by the House of Commons, on 15 January 2025, to be printed. It was published on 17 January 2025 by authority of the House of Commons.

Committee reports are published on the Committee's website at www.parliament.uk/healthcom and in print by Order of the House.

Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is hsccom@parliament.uk. You can follow the Committee on X (formerly Twitter) using CommonsHealth.

Second Special Report

The Health and Social Care Committee published its Second Special Report of Session 2023–24, Expert Panel: Evaluation of the Government's progress on meeting patient safety recommendations (HC 362), on 22 March 2024. The Government Response was received on 8 January 2025 and is appended below.

Appendix: Governement Response

Section 1: Maternity safety and leadership

This Government's general approach to this area

This Government is committed to ensuring that all women and babies receive safe, compassionate and personalised care. We will work closely with NHS England as it delivers its 3-year maternity and neonatal plan, to develop a culture of safety and ensure Trusts failing on maternity care are supported to make rapid improvements. This Government brought the death certification reforms, including the introduction of a statutory system of medical examiners, into legal effect on 9 September 2024.

Maternity safety recommendation

The accepted recommendation that the Expert Panel evaluated progress against is as follows:

"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."[1]

Response to the expert panel's evaluation of the Government's progress against this recommendation

The Committee has raised points about: the Government's decision following the consultation on stillbirths; adequacy of funding for the medical examiner system and the availability of data on perinatal deaths.

The Department of Health and Social Care and the Ministry of Justice jointly consulted on proposals to provide coroners with new powers to investigate term stillbirths in 2019. In 2023, a factual summary of responses to the consultation was published. The Government will provide an update on next steps in due course.

Progress has been made to access perinatal mortality data earlier than in previous years. January to December 2022 rates of stillbirth, neonatal mortality and extended perinatal mortality were made available to Trusts and published by MBRRACE-UK in March 2024. Previously this had been provided to Trusts in May or later. Data is also presented for the UK and for each devolved nation by MBRRACE-UK via their data viewer.[2] We are also collaborating with the Office for National Statistics to speed up data reporting and reduce the lag between the period covered by data and its publication.

NHS England is committed to creating the Submit a Perinatal Event Notification (SPEN) service in early 2025 (previously reported as summer 2024 in the plan) to make it easier for Trusts to notify national organisations of specific incidents. This includes notifying MBRRACE-UK and NHS England of perinatal deaths. These data will be received in near-real time. The intention is to use this data to supply a Maternity Outcomes Signal System tool which is being developed in response to recommendation 1 of the Reading the Signals report on East Kent maternity service. This will provide signals to Trusts when unusual levels of activity have occurred, so that the appropriate action can be taken. The tool will be available in Quarter 1 of 2025/26.

1 From The Report of the Morcambe Bay Investigation, page 190

2 Perinatal mortality data viewer | MBRRACE-UK

The regulations to reform death certification and introduce medical examiners came into force on 9 September 2024 and under these reforms all deaths are legally subject to either a medical examiner's scrutiny or a coroner's investigation. Together these reforms focus on the experience for bereaved people and seek to support improvements to patient safety. Importantly for bereaved people, the introduction of a statutory medical examiner system provides an opportunity for them to raise questions or concerns with a senior doctor not involved in the care of the deceased. The statutory system will also help deter criminal activity, improve practice and ensure appropriate referrals to coroners for further investigation.

As of 9 September 2024, the Medical Certificate of Cause of Death includes fields on maternal deaths regarding if the deceased was pregnant within a year prior to the death and, if they were pregnant, whether the pregnancy contributed to the cause of death. Recording information relating to pregnancy on the Medical Certificate of Cause of Death will provide a more accurate way to measure maternal deaths.

Leadership recommendation

The accepted recommendation that the Expert Panel evaluated progress against is as follows:

"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."[3]

Response to the expert panel's evaluation of the Government's progress against this recommendation

The Leadership Competency Framework (LCF), which was published in February 2024, provides a consistent competency and skills benchmark against which board members will individually self-assess as part of the annual 'fitness' attestation as set out in the updated FPPT framework (published in August 2023). The LCF is expected to be implemented in all NHS provider and commissioner organisations.

The competency domains have been built into the Chair Appraisal Framework which was published in February 2024 for use in 2023/24 appraisals. The competency domains will also be part of the Board Member Appraisal which will be published in Q3 of 2024/25. The LCF should be used by organisations as part of the recruitment process and ongoing annual appraisal processes. The training and development opportunities available

3 From The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, page 108

for all NHS board members on the NHS England website were refreshed and updated in Q2 of 2024. A new induction framework for Chairs and non-executive directors (NEDs) has been introduced, comprising a rolling series of national welcome days for new Chairs, CEOs and NEDs and will be complemented by an induction handbook for new Chairs and NEDs launching later this year.

In response to the Messenger and Kark reviews and the wider drivers for change including within the NHS Long-Term Workforce Plan (LTWP), NHS England's Management and Leadership Development Programme has developed a three-year roadmap for delivery through 2024/25–2026/27. Produced with the input of the Management and Leadership Advisory Group and the oversight of the NHS England executive Management and Leadership Committee, the roadmap sets out the activities which, collectively, will achieve the stated vision for excellence in NHS management and leadership. At the heart of the plans is an ambition to increase professional accountability and boost public confidence in NHS leaders and managers, increasing their sense of pride in their profession as follows:

- NHS leaders and managers at all levels meet the standards and competencies we should expect of them.
- All leaders and managers have access to high-quality professional development and support to meet the expected standards and competencies.
- The NHS attracts, develops and retains the best talent.
- The public has increased confidence in NHS leaders and managers, who feel a continued sense of pride in their profession.

The three-year roadmap covers three broad areas:

- Management and leadership standards and frameworks: NHS England will increase the professional accountability of NHS management by introducing professional standards and a code of practice, bringing greater consistency at all levels of management and leadership and greater parity with the clinical professions. This will be assessed through standardised appraisal processes and provide a framework for career development and progression. The Code of Practice, which will be applicable across health and social care, will be developed by December 2024 and standards and competencies by March 2025.
- Management and leadership development: Refreshed and accessible development programmes for managers and leaders at all levels aligned to the framework, to support staff in meeting the professional standards while ensuring they are equipped with the skills needed

to address the challenges facing the NHS today and into the future. A standardised curriculum for all leadership and management development to be developed by May 2025.

- Career/talent development and management: Initiatives to improve the attraction, identification, development and deployment of high potential talent leading to increased retention rates at all levels in the NHS. This will include refreshing and diversifying senior level talent pools and pipelines, improving succession planning and improving support for senior leaders moving to challenged roles and organisations.

Ensuring strong and accountable NHS leadership will be critical to fixing a broken NHS and delivering our Health Mission, driving performance and fostering a positive, compassionate, and transparent culture within the NHS while ensuring that local organisations are anchors of growth and opportunity in the areas that they serve. In November, the Department for Health and Social Care launched a 12-week consultation on options for regulating NHS managers. This forms part of a developing programme of work to meet the Government's manifesto commitment to introduce professional standards for, and regulate NHS managers, and builds on a wider programme of work being led by NHS England to develop standards, a code of practice, and a curriculum for NHS managers and leaders.

In addition to the leadership and management development work being taken forward by NHS England, we have committed to establishing a College of Executive and Clinical Leadership to help train and develop excellent NHS leaders and have asked Sir Gordon Messenger to look at how we can go further on developing a strategic approach to talent management in the NHS.

Recently in the Secretary of State's speech to NHS Providers, we announced a tough package of reforms to help tackle the NHS crisis and ensure there are 'no more rewards for failure.' This includes a no-holds-barred sweeping review of NHS performance across the entire country, with providers to be placed into a league table. This will be made public and will be regularly updated to ensure leaders, policymakers and patients know which improvements need to be prioritised. Those Integrated Care Boards (ICBs) and providers that are doing well will be rewarded with greater freedoms and flexibility over elements of their capital spending. We want to move to a system where freedom is the norm and central grip is the exception to challenge poor performance. Persistently failing managers will be replaced and turnaround teams of expert leaders will be deployed to help providers which are running big deficits or poor services for patients, offering them urgent, effective support so they can improve their service.

Section 2: Training of staff in health and social care

This Government's general approach to this area

This Government is committed to supporting a workforce that is professionalised, recognised and well supported, with opportunities for high quality learning which enables people to develop and progress their careers across an integrated health and care system. The implementation of new national induction resources for all new leaders and managers in health and social care will deliver significant benefits, including improving staff retention and embedding a sense of belonging at the start of people's careers, which we know is central to maintaining continuity and quality of care.[4]

Training of staff recommendation

The accepted recommendation that the Expert Panel evaluated progress against is as follows:

"Targeted interventions on collaborative leadership and organisational values. [including] A new national entry-level induction for all who join health and social care."[5]

Response to the expert panel's evaluation of the Government's progress against this recommendation

This Government shares the views of the Panel and stakeholders that implementation of a new National Induction Framework will deliver significant benefits for both the health and social care workforce, in relation to the retention of staff and the importance of embedding a sense of belonging at the start of their careers. The National Induction is in the final stages of development and will be launched in Q4 2024/25. The design and development of the framework has required lengthy stakeholder involvement across the NHS and social care and has been designed to ensure all organisations can provide a positive start for new staff.

The induction framework will provide a collection of resources to be used locally in a way that is most appropriate for organisations, managers and new joiners, including bite-size E-learning on key topics. It should also complement any existing arrangements that organisations have in place for

4 From The state of the adult social care sector and workforce in England, 2024, p.164

5 From Leadership for a collaborative and inclusive future

induction. Individuals will have access to it for as long as they need it. It will not be a one-off activity and staff will be able to return to it when they need to and fit this into their working pattern.

We are aware of the concerns raised by the panel about consistent implementation across both workforces – unlike the NHS, adult social care is not a single entity, instead comprising approximately 18,000 different employers, the majority of which are small and medium size organisations employing fewer than 50 people. This is a significant challenge. To address this challenge, we will deploy different approaches for both, whilst ensuring the content remains shared and consistent across both sectors, with a robust plan for implementing the induction framework in place across both NHS England and Skills for Care.

As acknowledged earlier in this response, NHS England has a comprehensive Management and Leadership Programme, where this induction framework will sit as a key part of the drive to strengthen standards and create a sense of belonging across all NHS services.

The Department of Health and Social Care has set aside funding to support implementation across adult social care, through its grant to Skills for Care to enable them to promote and embed these resources across the sector. Ahead of the launch of the joint induction resources, Skills for Care will engage its Registered Manager networks across England again, sharing key leadership messages and details of new staff induction resources. The resources will be promoted through a dedicated Skills for Care web page and communicated further through multi-channel rollout to support maximum engagement. Messaging will also be incorporated in scheduled marketing campaigns across adult social care where there is alignment.

The launch of the first phase of the Adult Social Care Workforce Pathway ("the Pathway") in January 2024 has helped to maximise communication and engagement on the Messenger recommendations across adult social care, for example, through collaboration with sector partners, such as ADASS, Care Quality Commission (CQC) and adult social care employer representative bodies. The first part of the Pathway included a 'Practice Leader' role category and the second part of the Care Workforce Pathway, due to go live in Spring 2025, includes both Registered and Deputy Manager role categories, as well as a role recognising where care workers also undertake routine healthcare activities, alongside suggested opportunities for learning and development. Depending on outcomes from the 2025/26 spending review, we will also explore development of new qualifications, supporting care workers to consolidate and progress their careers, as part of the government's plan to professionalise the adult social care workforce.

This, along with launch of a joint Managers' toolkit for health and care as part their online leadership and management offer, is further strengthening awareness and helping improve leadership capability across the sector.

The Government recognises the importance of learning, development and training and is committed to enhancing the skills of all staff working in adult social care, to ensure that people receive care and support which is high quality, fair, personalised and accessible. In addition to continuing to develop the Care Workforce Pathway, the new Level 2 Adult Social Care Certificate qualification has been developed and launched. Additionally, on 6 September 2024, the Department launched the adult social care Learning and Development Support Scheme, which allows eligible employers to claim for funding for certain training courses and qualifications on behalf of eligible care staff.

Successful delivery of these reforms is not just the responsibility of government but will require all health and care partners, including local authorities and independent care providers, to work together through their local Integrated Care System (ICS) to ensure effective system-wide coordination of recruitment and development. ICS Strategy Guidance, which was updated in February 2024, included strengthened guidance advising that ICSs should lead on joint workforce planning, talent management and skills development, alongside local authorities, as a crucial next step to achieving an integrated health and care workforce.

We are committed to moving towards a Neighbourhood Health Service, with more care delivered in local communities to spot problems earlier, supporting people to stay healthier and maintain their independence for longer. The workforce will be at the heart of these changes, with new opportunities to learn and share expertise across professional and organisational boundaries.

We have also introduced new duties on the CQC to assess local authorities' delivery of their adult social care duties, under Part 1 of the Care Act 2014. The CQC will consider if local authorities understand their current and future workforce needs and if councils are working in partnership with providers to develop, support and promote capable and effective care workforces.

By equipping the workforce with the skills to use and benefit from technology, we can improve the quality, safety and productivity of adult social care services. Under the last administration a comprehensive digital learning offer was delivered support providers to put the right foundations in place. This included an updated digital skills framework a training database to help employers and staff with their digital learning and 7 free-to-access eLearning modules to help people working in adult social care to develop a broad base of digital knowledge and skills.

As a part of the Data Security and Protection Toolkit, the information security standard across both the NHS and social care, care providers are required to meet a target of 95% of their staff having completed data and cyber security training. To help care providers to meet this requirement, the Better Security, Better Care Programme have produced free-to-access training so that every member of staff within care has the knowledge necessary to protect the data of those working in and receiving care.

Section 3: Culture of safety/whistleblowing

This Government's general approach to this area

Patient safety is a priority for the Government's vision for the NHS. When things go seriously wrong, it is the role of government to look closely across the system to understand what happened and put measures in place to prevent the same issue from happening again. There have been some efforts over the last decade to do so, including commissioning independent inquiries to get to the bottom of events, identify the failings and make specific, system-wide recommendations. The aim of these initiatives has been to encourage a positive culture of learning from patient safety incidents, put a widespread focus on reducing avoidable harm, improve safety and provide explanations to those affected. But these have not always delivered change in a consistent manner, and recommendations have not always been adopted.

Specifically on whistleblowing, we want NHS staff to have the confidence to speak out and come forward if they have concerns and have been clear from the outset that we will not tolerate NHS managers who silence whistleblowers. Evidence from the National Guardian's Office and NHS staff surveys shows we have more work to do to create a culture where every worker feels safe to speak up and confident that their concerns will be heard and addressed.

Culture of safety recommendation

The accepted recommendation that the Expert Panel evaluated progress against is as follows:

"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."[6]

Response to the expert panel's evaluation of the Government's progress against this recommendation

We accept that there have been efforts by previous Governments over the last decade to grip this, including commissioning independent inquiries to identify and consider in detail the failings and make recommendations including those that that can be applied to improve patient safety. Since 2012, previous Governments have taken a number of measures aimed at raising patient safety standards and fostering a transparent safety culture across the NHS. These changes include:

- Implementing a statutory duty of candour for NHS trusts and NHS foundation trusts from November 2014 and for all other health and social care providers registered with the CQC from April 2015.
- Enhancing legal protections in 2018 for NHS whistleblowers by prohibiting certain NHS employers from discriminating against job applicants because it appears to the employer that the applicant has made a 'protected disclosure', alongside longstanding protections for all whistleblowers under the Public Interest Disclosure Act 1998.
- Establishing a network of more than 1,300 local Freedom to Speak Up Guardians across healthcare in England, supported by a National Guardian, established in 2016, to lead positive culture change in the NHS and make speaking up the norm.
- Establishing the first Patient Safety Commissioner in 2022 with a statutory remit to amplify patient voice in relation to the safety of medicines and medical devices.
- Establishing the Health Services Safety Investigations Body in October 2023 as a new arm's length body to conduct independent, expert-led national safety investigations. This body continues the work of the Healthcare Safety Investigation Branch, which was itself established in 2017.

Although well-intentioned, these initiatives have not always delivered change in a consistent manner.

6 From Freedom to speak up: an independent review into creating an open and honest reporting culture in the NHS, page 24

Patient safety is a priority for the Government's vision for the NHS, and since July significant steps have been taken. In September 2024 this Government brought the death certification reforms, including the introduction of a statutory system of medical examiners, into legal effect. In October 2024, the Department of Health and Social Care published findings of a review of the CQC's operational effectiveness,[7] led by Dr Penny Dash, which uncovered significant failings in the internal workings of the organisation, including poor operational performance, and loss of credibility within the health and care sectors. CQC have now developed an approach to recovery that supports addressing the recommendations in Dr Dash's review. We have also asked Dr Dash to conduct two further reviews with a focus on patient safety and quality.

As mentioned earlier, in November 2024 we also launched a 12-week consultation on options to bring NHS manager into regulation, which includes seeking views on:

- A new professional duty of candour to cover managers (in the same way this applies to all regulated healthcare professionals).
- A duty on managers to ensure that the existing statutory (organisational) duty of candour on providers is complied with in their organisation.
- Making managers accountable for responding to concerns about patient safety.

Alongside the consultation the Government also published a report on the findings of a call for evidence on the duty of candour launched in April 2024. The findings from the call for evidence suggest that the impact of the statutory duty of candour over the last decade has been broadly underwhelming. A majority of respondents thought the duty's purpose was not clear; that staff across health and social care do not understand the duty's requirements, and application is inconsistent/misinterpreted; and providers do not engage patients in a meaningful or compassionate way. The Government will use the findings of its consultation on regulating NHS managers and the call for evidence to help inform the final response to the review of the statutory duty of candour.

Turning to this particular recommendation, on Action 1.1, whilst this is a recommendation for Boards, safety culture is multi-faceted and requires mechanisms for Boards to measure, monitor and publish progress in creating a safe learning culture are multi-faceted. As part of its focus on patient safety culture, NHS England have worked across healthcare sectors,

7 Review into the operational effectiveness of the Care Quality Commission: full report - GOV.UK

including primary care, to develop guidance on what works well including publishing *Safety culture: learning from best practice*.[8] NHS England subsequently developed *Improving patient safety culture: a practical guide*,[9] which has also been well received.

On Action 1.2, the CQC's Single Assessment Framework includes a dedicated Freedom to Speak Up quality statement,[10] which sits within the Framework's 'well-led' domain. The quality statement applies to all registered providers and was developed with the National Guardian's Office and forms an integral component of the Single Assessment Framework.[11] The statement emphasises the importance of a positive culture where people can speak up and staff and leaders act with openness, honesty and transparency. This is an integral part of the overall framework CQC uses when making judgements about providers. CQC have also produced guidance jointly with NHS England on the assessment of 'well-led' at Trust level.[12] As set out earlier, there is significant work underway to improve CQC's operational effectiveness following the findings from Dr Penny Dash, including a review of the Single Assessment Framework,[13] published on 15 October 2024.

We note what the panel have said in their report about the inconsistency of application of Freedom to Speak Up. In 2022, under the previous Government, NHS England published a national Freedom to Speak Up policy, which provides the minimum standard for local Freedom to Speak Up policies across the NHS. Supporting guidance, co-produced with the National Guardian's Office, supports leaders to encourage a 'Speak Up, Listen Up, Follow Up' culture. NHS England and the National Guardian's Office have also developed a self-reflection and planning tool to be used by Boards in conjunction with the guidance to help senior leaders identify strengths in themselves, their leadership team and their organisation, and any gaps that need to be addressed. NHS England wrote to all ICB Chairs in October 2024 to ensure the application of the guidance and self-improvement tool mentioned above by all Trusts and ICBs and ensure access to speaking up routes for primary care workers within their health system, with the aim to develop consistent speaking up cultures across organisations. We will ensure the panel's comments are factored into future work to improve speaking up and safety culture in the NHS.

8 NHS England » Safety culture: learning from best practice
9 NHS England » Improving patient safety culture – a practical guide
10 Freedom to speak up - Care Quality Commission (cqc.org.uk)
11 Freedom to speak up - Care Quality Commission, 2024
12 Freedom to speak up - Care Quality Commission
13 Review of CQC's single assessment framework and its implementation - Care Quality Commission

The panel also reported findings about the variability in leadership on boards, who may not have the skills to challenge reports on patient safety. The NHS Patient Safety Syllabus training is building knowledge, capability, and capacity in 'systems-thinking' and patient safety science through the creation of the first system-wide standardised approach to training and education in patient safety across the NHS. Level 1 and Level 2 are available for all staff via the E-learning for Health Platform, including a specific module for Boards and Senior Leaders. During 2023/24, NHS England's national patient safety team sought feedback from Board members currently working in the NHS, including Non-Executive Directors, on how to make the e-learning module more impactful. NHS England have been working with Patient Safety Specialists to develop resources to support them to deliver the syllabus in alternative, standardised formats to reduce variability with local safety knowledge.

On the panel's comments about lack of funding for the Freedom to Speak Up Guardian role, there are no plans currently to provide dedicated funding to implement the Guardian role. Where the Guardian role is working most effectively, it is because organisations understand its importance to the whole organisation in improving patient and staff experience and invest in the role accordingly. In terms of achieving greater consistency in the future, whilst individual organisations have been given the space to decide how the Guardian role should be implemented, we would consider giving further direction if that is needed in order to achieve a more consistent standard. To support this the National Guardian's Office are reviewing and revising the universal job description[14] to better support Trusts to implement the Guardian role in line with best practice.

The panel also reported variability in the implementation of the Patient Safety Incident Response Framework (PSIRF). PSIRF overhauls the way Trusts respond to patient safety incidents with a focus on understanding how incidents happen and more effective learning. PSIRF is a component of the NHS Patient Safety Strategy, led by NHS England and first published in July 2019. It is the first whole-NHS strategy designed to support the entire NHS system to achieve continuous improvement in safety and the reduction of patient harm while embracing an ethic of learning.

We will ensure the Expert Panel's comments and findings are taken onboard as this Government takes forward the necessary work relating to this important recommendation. The CQC will continue its work to address Dr Dash's findings. Further work heavily focussed on patient safety is also underway, including a second review by Dr Dash, this time focussing on six core bodies that have a patient safety role and how they work within the wider landscape. In due course we will publish details of a further review

14 Job Description - National Guardian's Office

to be conducted by Dr Dash focussing on quality and its governance, to guide our next steps in driving positive cultural change across health and social care. All findings will inform our 10-year health plan, as well as work to develop an NHS Quality Strategy, to transform the NHS and social care system and make it fit for the future.

Whistleblowing recommendation

The accepted recommendation that the Expert Panel evaluated progress against is as follows:

"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."[15]

Response to the expert panel's evaluation of the Government's progress against this recommendation

As previous inquiries have identified, an essential element in promoting patient safety is the ability of staff to escalate concerns and, more broadly, for complaints to be made and handled appropriately. A culture of openness and honesty is vital for patient safety. It is why the Secretary of State has been clear that the Government will not tolerate NHS managers who silence whistleblowers and wants NHS staff to have the confidence to speak out and come forward if they have concerns.

In response to a recommendation of Sir Robert Francis KC in his Freedom to Speak Up Review of 2015,[16] the then Government established an independent National Guardian in July 2016 to help drive positive cultural change across the NHS so that speaking up becomes the norm. In his review, Sir Robert

15 From Freedom to speak up: an independent review into creating an open and honest reporting culture in the NHS, page 28

16 The Report | Freedom to Speak Up Review

called for a more consistent approach across the NHS and a coordinated drive to create the right culture. In addition to driving cultural change, the National Guardian provides support and leadership to a network of over 1,300 local Freedom to Speak Up Guardians throughout healthcare in England. Their role is to help and support staff who want to speak up about their concerns. The National Guardian also issues guidance and training on how to speak up.[17]

Since 2003, there has also been a helpline in place for health and social care staff who need support to raise a concern. From 2017 this service became known as 'Speak Up Direct'. It is currently delivered by an organisation called Social Enterprise Direct. Support is available online or via a telephone helpline.

The National Guardian's latest report on speaking up to Freedom to Speak Up Guardians for 2023/24 showed that guardians handled more cases than ever before (over 30,000 cases, representing a 27% increase on the previous year[18]). It also states that there remains a persistent number of cases where Guardians indicate that the person speaking up to them may be experiencing detriment for doing so and a separate NHS Staff Survey analysis by the National Guardian's Office revealed the percentage of workers feeling secure enough to raise concerns about unsafe clinical practice reached a five-year low at 69.4% in 2023.[19] This tells us that there is much more to do in this area. The Government will consider what further action is required to make speaking up, listening up and following up the norm in the NHS.

Turning to this particular recommendation, on Action 19.1, whilst Freedom to Speak Up has not been added to the GP contract, the General Practice Annual Electronic Self-Declaration (eDEC)[20] has for a number of years required GPs to confirm that they have Freedom to Speak Up arrangements in place. Every GP practice should submit the eDEC as it is a mandatory return, and it should be completed by a senior member of the practice staff. ICBs have a key assurance role in ensuring that all NHS organisations across the area have accessible Freedom to Speak Up arrangements, with supporting guidance[21] published by the National Guardian's Office and NHS England in 2023.

On Action 19.2, in 2017 NHS England published guidance for primary care providers on Freedom to Speak Up.[22] This guidance is for all providers of

17 Freedom to Speak Up - elearning for healthcare, 2022
18 Speaking Up Data - National Guardian's Office, 2024
19 Speaking Up Data - National Guardian's Office, 2024
20 General Practice Annual Electronic Self-Declaration (eDEC) - NHS England Digital
21 Guidance for Integrated Care Boards - National Guardian's Office
22 Freedom to Speak Up in Primary Care

NHS primary care services (GP practices, dentists, opticians and community pharmacists). It details the principles and actions to apply in primary care to support the raising of concerns by staff about the delivery of primary care services to patients and the management of the matter raised. This guidance emphasises important principles, including that all NHS staff working in primary care should be encouraged to raise any concern at the earliest opportunity and NHS primary care providers should be proactive in preventing any inappropriate behaviour, such as bullying or harassment, towards staff who raise a concern.

On Action 19.3, as mentioned earlier, the CQC's Single Assessment Framework includes a dedicated Freedom to Speak Up quality statement,[23] which sits within the Framework's 'well-led' domain. The quality statement applies to all registered providers and was developed with the National Guardian's Office and forms an integral component of the Single Assessment Framework.[24] The statement emphasises the importance of a positive culture where people can speak up and staff and leaders act with openness, honesty and transparency. This is an integral part of the overall framework CQC uses when making judgements about providers.

We welcome the panel's findings that good progress has been made in rolling out improved guidance with regards to patient safety more widely, and the evidence that some ICBs are implementing processes to ensure staff are able to speak up. We also note the panel's findings that success is not evenly distributed and that primary care professionals are less likely to engage with Freedom to Speak Up Guardians or other speaking up channels. NHS England have asked ICBs to ensure that all primary care workers in their health system have access to Freedom to Speak Up routes, including a Guardian that is trained and registered with National Guardian's Office.

Recent work has also been undertaken by the National Guardian's Office to support Primary Care to implement the Guardian role. This includes:

- Creating a primary medical services network, which aims to support Guardians to discuss issues and have support from a peer-to-peer point of view.
- Hosting a webinar regarding the updated recording and reporting guidance which was published and announced in the National Guardian's Office's Bulletin. Reporting and recording is part of the role of the Guardian therefore any new Guardians employed across primary care will be aware of the requirements.

23 Freedom to speak up - Care Quality Commission (cqc.org.uk)
24 Freedom to speak up - Care Quality Commission, 2024

- Hosting an ICB roundtable with ICB Guardians to discuss implementation and reporting arrangements. An ICB Guardian Network is to be established and hosted by the National Guardian's Office.

NHS England will continue to work with the National Guardian's Office to support ICBs with their role in Freedom to Speak Up through its ICB Guardian Network, using the models identified by the National Guardian's Office in their 2021 report, *Exploring Freedom to Speak Up: Supporting the introduction of the Freedom to Speak Up Guardian role in Primary Care and Integrated Settings*.[25]

25 Exploring Freedom to Speak Up in Primary Care and Integrated Settings - National Guardian's Office