**Written evidence submitted by Group 1 (PSN0030)**

Transcript of roundtable event with health and social care professionals held on Tuesday 30th January 2024 to inform the Health and Social Care Committee Expert Panel evaluation of government progress on implementing patient safety recommendations

**Start of transcript**

**Professor Emma Cave:** Well, thank you so much everybody for coming. We appreciate it very much. I've just introduced myself, I'll briefly say again, I'm Emma Cave. I'm a professor of healthcare law and I'm one of the core members of the Expert Panel to the Health and Social Care Committee. I hope you don't mind if we use first names today, just keeps it a little friendlier and easier.

OK, so the background reading that we have done on the Expert Panel suggests that public inquiries and reviews often make recommendations to improve patient safety; but although the government accepts at least some of these recommendations, when it comes down to it, the recommendations aren't always implemented or implemented very well. So in a moment, we're going to ask you about some of those specific recommendations that have been accepted by government and we would really like to hear your views on if, and how far, the recommendations have or haven't been implemented in practice.

Right then, if we can just go through a few introductions. We've got about an hour and a half. So we've got some time. So as was mentioned earlier, if we finish early, that's fine too, we can all go and do something else, but we've got an hour and a half, so we've got plenty of time. OK. So if we could start off with Participant 2 please, if you could just introduce yourself?

**Participant 2:** Hi everyone I hope you can hear me. My microphone has been playing up. I'm Participant 2 and I am a manager, Freedom to Speak Up Guardian and I'm also a union rep. Nice to be here. Thank you.

**Professor Emma Cave:** Thank you very much. And Participant 3?

**Participant 3:** Hi, I'm Participant 3. I am an [allied health practitioner] by background but I've moved into organisational development and lead on culture work within my organisation and I'm one of the lead Freedom to Speak Up Guardians for the trust. I work in an acute provider trust, a medium-sized one of around 9,000.

**Professor Emma Cave:** Fabulous. Thank you very much. And Participant 4?

**Participant 4:** Hi I'm a medical examiner and also a GP [General Practitioner] by background.

**Professor Emma Cave:** Marvellous. And Participant 5?

**Participant 5:** Hi, can you hear me?

**Professor Emma Cave:** Perfectly.

**Participant 5:** Yeah. OK, so I'm [a doctor who blew the whistle on several issues and experienced very negative consequences].

**Professor Emma Cave:** You've got quite a story to tell Participant 5, and you're very welcome here.

**Participant 5:** Thank you.

**Professor Emma Cave:** And I'm so sorry for everything that's happened, but it's going to be very relevant and important to hear what you have to say. So thank you for that. Participant 6?

**Participant 6**: Hi everybody, I'm a Participant 6 and I'm the lead medical examiner working regionally with Participant 4. I'm also the clinical lead for a programme. So we're kind of broad-ranging in that experience with helping trusts learn from deaths and improve. I think is the short description.

**Professor Emma Cave:** That's marvellous. Thank you so much. And Participant 7?

**Participant 7:** Hi, I'm Participant 7 and [I work on social care workforce development].

**Professor Emma Cave:** Marvellous. Thank you. And Participant 1, back to you.

**Participant 1:** Thank you. Participant 1. I currently work with [Local Authority] until April. I'm regulated workforce practice manager so I support the regulated workforce, which is social work and OTs [Occupational Therapists]. I work in training and development with adult social care [in a leadership role].

**Professor Emma Cave:** Thank you very much. That's marvellous. I haven't forgotten anybody, have I? I don't think so. No, that's brilliant. OK. Well, let's get going there. We're going to focus on some particular commitments that we've chosen, out of the very great number of commitments that have come out of the various inquiries, that were made by the government in relation to three areas in particular that we're going to look at today. That's maternity and leadership; staff training; and culture. They all concern recommendations from inquiries that the government subsequently accepted, and it may be some overlap between some of the themes that we'll cover, but I'm going to ask each of the questions anyway, and we can just say, "well, we've already dealt with that" if that's the case.

So as I say, we've got until 16.45, so we've got quite a long time. We've got approximately 30 minutes for each of these issues. And we're going to start off with maternity care and leadership. So this is the first area and we've chosen 2 recommendations for this particular area.

The first one comes from the Morecambe Bay investigation and the second one comes from Mid Staffs. So the first one is around this issue: that 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. So that was stated in 2015 from the inquiry into Morecambe Bay. And our question is, how well has that been actually implemented, if it has been implemented at all. So the question for you is then: how successful is the English system of medical examiners, first of all, to focus on that aspect, at identifying problems in maternal and perinatal deaths? And I wonder if we could perhaps start with Participant 3 perhaps on that one, if you have something to say on it, which I would imagine you do.

**Participant 3:** I would feel that I don't have an awful lot to stay on this one. I mean, within the medical examiners, I don't think I would feel like I had, I'd be interested to see what other people say, but I don't think I would have a lot of experience in that side of things at all.

**Professor Emma Cave:** OK.

**Participant 3:** I think with yeah, more around speaking up if people are concerned, but I don't think… as a starting point, probably not.

**Professor Emma Cave:** OK. Alright, that's absolutely fine. So how about Participant 4? I think, perhaps you're expert in this?

**Participant 4:** Yes, well, I know a bit about it. Not necessarily expert, but I do know a bit. So yes, we are reviewing deaths and the medical examiner service has started. Participant 6 will correct me if I get my dates wrong, but pilot schemes started around after the 2009 Act came in. And then I think the trusts were required to then set up a medical examiner office - the acute trusts - around 2018. Participant 6 is that correct? And then from that time, we've been gradually increasing the numbers of deaths that we've been reviewing. And so that's all deaths. So that's adults, children, maternal, neonatal deaths. And then over a period of, between then and now, we've started rolling out into primary care as well.

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.

So each medical examiner office is working slightly differently. Where I am, we are reviewing all main site acute trust deaths. So if we had a maternal death or a neonatal death, we would be reviewing those cases, however, [region] have relatively low level neonatal care, so we in [area 1] only take babies over 32 weeks gestation and [area 2] only over 28. So actually, if we have poorly babies, they often are transferred out of our trust. So our numbers - and I've checked again this morning - we haven't had any neonatal deaths since our service was started to review and fortunately we haven't had any maternal deaths to review. However, they would come through our system if they happened. Which is reassuring, I think.

**Professor Emma Cave:** That's fantastically helpful. Thank you. And I'll come to Participant 6 in just a second, if that's alright, Participant 6? I just wondered if you can say a little bit more about some of the barriers. So you talked about the pandemic being a barrier and IT systems. Do you have a sense that perhaps they can be overcome by April or does that really seem unlikely?

**Participant 4:** I think if this just became statutory, we would have to do it. And we would have to review the case notes of every person who dies. And I think there would be ways round that. Whether they would be perfect, not sure, but there would be ways around it. For example, we have some GP practices where they're on a different IT system that the trust doesn't link into, but they can send us a summary and we can request copies of various letters and notes and things. So there are definite workarounds. But each different IT system requires a different workaround. There is a lot of effort to get it up and running but I think it is achievable in my opinion. In some ways if it came in, then we would be doing it, because that would be the law.

**Professor Emma Cave:** OK. That's great. What about workforce issues? Is the workforce there that's needed for it?

**Participant 4:** 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. You know, a GP practice may send to a hospital or a different hospital. So it's really difficult. It sounds like it should be simple to say, "how many people die in your area?", and it's just impossible. So until we're statutory, I think it's very difficult to know exactly how many deaths we will get. I think there are doctors that would take on the medical examiner role because it's a fascinating role, it's really interesting and so I think the personnel would be there. The concern is that it's taking personnel away from other areas where obviously we are short on doctors already. But that's a kind of ethical moral debate. So I think that it would always be welcome to have more funding, but how much more funding is needed? I can't say until I know how many deaths.

**Professor Emma Cave:** That's fabulous. So helpful. Thank you, Participant 4. That's brilliant. So can I turn now to you Participant 6, to fill in some of the gaps that you might perceive or give your point of view?

**Participant 6:** Slightly different point of view in that we have done some neonatal deaths as well as - within Covid I think we had a couple of maternal deaths, and you do handle them differently. We've been a fairly small trust and at a similar stage to Participant 4 in that we've been doing all of the inpatient deaths for some time now. We've been doing that fully for nearly three years. And we work alongside the bigger trust in the region, which is our specialist unit. So as Participant 4's described, some of those maternal and neonatal deaths happen in bigger centres, so there is a different representation of that within medical examiner offices across the country in terms of their activity in the presentations and then the expertise built.

Maternal deaths are actually easier to scrutinise because we have agreements in place to access those records. And we see the records in hospital, we see in them in their entirety, and we can get a conversation with clinical staff. We've all got very strong links with our local coroners. But those links are different. So local coroners do different things and accept different levels of clinical evidence. They have local rules. They're not really supposed to, but they are not a national service. And as Participant 4 says, the medical examiner offices all work slightly differently. We get the same money, we get the same number of full-time equivalent staff, but how we're constituted and how we actually perform is subtly different. So there are already differences that were built in how the evidence is gathered.

Neonatal deaths are a little bit harder because we have permission to look at the notes of anyone who is dead. We do not have the same permissions to access the notes of anyone who is living, and that's the mother. So we're then in the difficult position of, how do we view those maternal notes, and have we got consent? And we're all trying to find ways through that. And you can imagine the sensitivity there. We are all very conscious that you've got a grieving mother who came in pregnant and is going to have to go home, as somebody described it, drive home with the empty car seat. So actually being able to talk to mothers is very difficult in that situation.

And we've got one group that's particularly awkward that we've come across where, should you have a termination, a planned surgical termination and there are any signs of life, that is automatically a coronial case. And we've had a few like that. And you can imagine having gone through the agony of deciding on that termination for medical reasons, to then be told, "well I'm sorry, this is coronial". And that has been very difficult. And we've had three of those, all of which were deeply uncomfortable, but by law you have to do the right thing.

In accessing neonatal notes, you're actually then dealing with two different clinical teams potentially, who have a different reluctance in coming to speak to medical examiners. Now that's quite understandable. You've got a paediatric team that are usually involved in that resuscitation and then you've got the obstetric team involved in the delivery, whether it's by C-section or other general delivery. So it becomes quite complicated to speak to the professionals. And you can imagine that some of the obstetricians would rather that the paediatrician spoke to us and vice versa. So that's a little bit difficult. And then you've still got a family to speak to.

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 med so for our team it's pretty straightforward, but that makes me quite unusual. I think there is that expertise gap. Certainly in [my area], we've had some WhatsApp discussion - and I promise we haven't deleted them every night - but we've had WhatsApp discussions about, how much neonatal paediatric expertise do you need to scrutinise those deaths? When's our level of suspicion raised? And I suspect as non-specialists our level of suspicion is going to be even higher because we worry about this. Which in some ways is good considering what we're talking about.

Going now into community deaths. Should an event happen in the community, it is very likely that that would be straight referred to the coroner. And we would need then the coroner's expertise. Are they going to have the expertise needed for this? We simply don't know. They're likely to come and ask us, I think, as we go forward.

In terms of the IT, I think Participant 4's been quite polite about the IT. I might be less polite. I can be politic, but I don't always bother. The IT to support us just doesn't exist. What was initially designed was, frankly, crap. Which means that we're going to miss themes and trends. We've all got different case management systems. Every office has got a get around. Every office will try and think of the themes themselves, which in small numbers is difficult, will introduce a bias. There is no collective way to get themes and trends across the country in the medical examiner service. And I can't emphasise that enough.

The NHS Business Services Authority has been commissioned to develop that database. I know that a lot of money has gone towards it but we have nothing workable. And I'll be honest and say, I think that's a disgrace. We've been up and running for a long time now. Yes, we talk a lot about this area, but I have a real concern that the themes and trends we should be talking about are those affecting the elderly. Shipman of course was in the elderly. But we know that all of these cases are being referred for other case reviews. So they have scrutiny. They potentially have coroner. MBRRACE [Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries] case reviews are undertaken and there is variable feedback from the MBRRACE case reviews. So I'm less worried about the ME [Medical Examiner] scrutiny, but we need to think, "what happens next? What happens to the case review that is in place? How does that information come back? What is the feedback look that would then tell Participant 4 and myself to know what to look for next? What's the little alert that would then tell me 'could you keep an eye out for XYZ?' Is there something that I should be looking for in the future because we're getting a hint?". And we have no process like that. Participant 4 I'm sure I've missed something, but that lack of thematic analysis is a deep concern to all the MEs.

**Participant 4:** Yes, completely agree. You've put it very well.

**Professor Emma Cave:** Well, this is incredibly valuable. Thank you both very much. I'd like to open it up to anybody else now. If anybody else has any comments about the medical examiner system in

particular, before we move on to other issues? No, OK. That's fine. I would like just to follow up though. The medical examiner system, how we do…

**Moderator:** I think Participant 1 has her hand up, Emma.

**Professor Emma Cave:** I beg your pardon. Sorry, Participant 1.

**Participant 1:** No, it's OK. I work in the social care world and not necessarily in the health world. It just strikes me as odd that it's not mandatory. And interesting as well. I guess they're two completely different areas, but from my colleagues in [region], that work in the ICBs and ICSs, if there's something around delivery that comes down, that is their absolute Bible. They will meet that at all costs. So it's just interesting what you say, Participant 4, that they've said that it will be implemented in April this year, but that by your experience reads “at some point”. It's interesting that there is that slippage. Because it must be extremely difficult to be able to plan for the impact of this and to organise resources to support it. So it's not necessarily a question, it's just a bit of an observation from me.

**Participant 6:** It's a very valid observation. As we both came into being MEs and took the roles on, we were told it was going to be ’23, bought into that, tried to get systems in place for that. And it slipped largely because of community engagement, I suspect, in truth. We now have the legal framework for it, so we've got the statutory framework. That came out in December. We were told at a meeting that once that was out, that was it, we were going to be statutory. So we're going to poised, because like you, we can't think why it's not. But even in that meeting, we were told that it would be in April, but it couldn't be April the 1st because that was a public holiday. And we're saying, “So what?” But then it was “Oh well, there's Easter”. And then there's something else near. We are sitting on the call, thinking, “can't they just pick a number?”

And I think it's been, behind the scenes at that political level, I think it has been quite difficult. I think it's been emotive. I think trying to get the legal framework has been very difficult. Because, you know, I've mentioned one law that pertains to one situation, but there are so many different legal aspects to this that have got to be looked at again. All the coronial stuff, the registrar births and deaths stuff. The death certificate has existed since 1953 - it's at the top of every page - and then we've got this new statute that relates to us. And I think being able to sit back and listen to the leads trying to do it, it's been incredibly complex to get that legal framework to where it is now. You think it's easy and it's not. And we go back, Shipman, the verdict was what, 14 years ago, Participant 4? And that's where… 14 years to get it going because it's just not easy. So when we say from April, we're hoping April the 2nd, I'm working to April the 2nd, but we still don't know.

**Participant 1:** I think what I was going to contribute to there probably doesn't touch on the complexity that you've just set out. Although it's so helpful to understand that because now I can appreciate that this is quite a feat to pull together. I'm just thinking of my social work colleagues in terms of some of the added support that this would bring. So I think about children's social workers and adult social workers, where there are already families - either known or unknown at that point - but where there are other siblings in that family where then, they come back with the empty car seat or the mother is lost as well. There's all sorts of different factors around the social care element of this as well that I think… Aside the grieving process, you can take a lot of comfort in data when you have something written down. So I would hope that when this all becomes set up and in place, that is an area that will benefit from this additional information, that will help to bring some context and comfort for people that are dealing with this, both on a professional level and hopefully at some point on a personal level too.

**Professor Emma Cave:** Thank you very much, Participant 1. I'm going to bring Participant 2 in now, but then we do need to move on to one of the other questions.

**Participant 2:** So my point is just going to be very short, more of an observation. So as Participant 1 was talking about impact beyond the immediate either mother or the family that's been impacted by the loss of mother and baby, is the professionals around that incident and how that impacts them. So I think having those themes… Because nobody goes - well, you'd hope nobody goes into to work to do harm or to lose a patient. So the lessons learned, we do RCAs, et cetera, but if there's additional information that could be accessed that would give people comfort of, "OK, this is what happened, this is where there are areas of improvement. Because we want to know what happened, what could we have done differently, better". That information would be helpful. So I'm hoping that this constant delay won't happen and that there will be a date in April and a system to provide those themes, because I think it would be really valuable to have that.

**Professor Emma Cave:** Thank you. Participant 6, is it burning? Because we really do need to move on to some other matters.

**Participant 6:** It's just a comment about that shared learning, because what we have to remember is there is no current database for the coronial findings. So when the coroner comes out with a narrative verdict, it's actually quite difficult for staff to see that. So the learning from Plymouth is not having an impact in Cleveland. And Morecambe Bay's outcome doesn't help South. So there is something about that. It's because the coroner service, again, is not a nationalised service. I do know somebody who has done it as a postdoctoral research project and has developed a tool to interrogate that. But she had to do it as a research project. Well, that's nuts, isn't it, really? We ought to be able to share that learning as well because you're absolutely right, it gives comfort to the families that we're all learning and it starts to look through themes and trends and lets people see. But there's something about a timely sharing to reassure staff. You know, do they get their feedback? And they don't. It can take months before staff are reassured that actually, "do you know, on the day you did something reasonable". So staff support after a death in their care is not always fantastic. We don't look after our NHS staff very well. Participant 5, you're one of the best examples. Our worst examples. But we don't look after staff when there's been an event like this, we blame them and anyone who thinks there isn't blame in the NHS is just delusional.

**Professor Emma Cave:** OK. So thank you, Participant 2, for bringing that up and Participant 6 for your follow-on point, because that is very, very important that we have captured that. So thank you very much and quick follow up. I want to stick to the context and maternity. Obviously, the medical examiner scheme fits alongside a number of other mechanisms like MBRRACE and the perinatal mortality review tool. Does anybody have a view as to how far the combination of measures is effective in improving maternity safety? Or whether there are gaps? Or there's overlap? Or whether it's too complex because there are so many different mechanisms that we're relying on for different groups, whether it's neonates or the mother or et cetera, et cetera. I just want to open that up to the group in case we run any comments on that. Participant 3.

**Participant 3:** I don't think I've got vast experience with those different ones individually, but I do think there is something in when there are multiple different systems and every time there's a review there's an extra system brought in. And it gets to the point where you are, there's so many things that you're trying to uphold and they're not brought together and delivered in a way that it's actually manageable for people on the shop floor to deliver on what is being asked. And I think it then becomes what people may perceive as like a tick-box and then it loses its value and the importance of it and then it doesn't get done. And then that's when issues happen again. And it's because, if you just keep adding and adding and adding and adding, I don't think the value is realised. So that's not on, that's not particular to the exact systems that you've described, but I would just say generically across the NHS in all areas, the scrutiny gets higher and higher, but we never consolidate on each time. That would be my view.

**Professor Emma Cave:** OK. Thanks, Participant 3. Was anybody else want to come in on that? Shall we move on? OK. So thank you. That's such a brilliant start, and I know we could already go on for about 6 hours, couldn't we? So if anybody gets tired, please do tell me. Everybody's welcome to go off for a minute if they want to. Or we could have a 5-minute break if that's needed.

So let's look at the second recommendation for this first area then. And that is around the common code of ethics standards and conduct for senior board-level healthcare leaders and managers. The idea was that this should be produced and steps taken to oblige all staff to comply with the code. And that came from Mid Staffs. So this is a change of tack, it's about how managers are governed.

So what's happened since then in 2013, is the Professional Standards Agency has produced standards for NHS boards. That happened in 2013. Then NHS England set out a code for corporate governance in 2014. And that's just been updated. And then the Kark review - and Tom Kark KC is in another breakout room on this call - subsequently made various recommendations to improve effectiveness, and a new Fit and Proper Persons Test framework was introduced. And that again has a deadline, I think, of April 2024.

So the question then is, in your experience, how effective has this been? Has it been effectively implemented? Do all senior board-level healthcare leaders and managers have a code that they can comply with? Is it properly enforced and implemented? Any question? Any comments? Participant 6, I think you're going to speak.

**Participant 6:** I'm waiting for Participant 5.

**Professor Emma Cave:** All right, you go ahead then, Participant 5.

**Participant 5:** Well, I was just going to say I think the code is there, isn't it? The expectations are there. But certainly my experience, and obviously I haven't worked in the NHS since late 2016, but I've certainly had ongoing contact with the senior executives there and it is ongoing at the moment. 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.

**Professor Emma Cave:** OK. Thank you.

**Participant 5:** Does that help?

**Professor Emma Cave:** It does help. It all helps. Participant 6 do you want to come back on that?

**Participant 6:** I think the calibre of executives and non-executives is hugely variable up and down the country. And I think there is an unfortunate reliance on some locum and agency staff who swoop in some of these roles, stay long enough not to get caught in the havoc and then go on to the next one. There's an element of that that goes on. And I do think, in fairness, the training and support for these roles is not really good enough. We train as consultants, we don't really get an awful lot of support as we go up the ladder, you're kind of in a clinical director post before anybody thinks to train you for that post. So it's always post-hoc. And the same thing happens with some medical directors. And I think you could translate medical for nursing; nursing suddenly get told they're working for allied health and yet they may have no great experience of allied health and suddenly they speak for them.

And 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 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.

And it can be very difficult to break that because you're breaking a culture. And boards have a culture that infects the whole organisation. And you know, we've got A Freedom to Speak Up Guardian nodding here. It can be very difficult to break the culture from the outside in, and also from the bottom up. And often it's without malice. It's a really interesting sort of biosphere, the NHS. It's odd.

And I think the link with social care: we've got a different kind of culture going on and the two don't necessarily talk to each other very well in safeguarding or in learning. And then we're going bring in primary care.

So we're pinning a lot of hope on ICBs here and how ICBs are actually going to help with that cultural change, oversight. And yet we've just appointed a whole lot of people with no training. And you can see what's going to happen. Very hard for an ICB to govern this really. We've no idea where we're going to report in, have we Participant 4? We think we're going to report to the ICB. We think we'll be able to feed back to the ICB if we see things, but we don't know what they're going to do. And I think we're potentially repeating something that happens at board level to then be at regional level. I might be pessimistic - I want to be really optimistic because there are great people involved. But unless the structures and support are there, ethics are written on paper. I'd agree with Participant 5, ethics are there and people know of them but working to them is different.

**Professor Emma Cave:** OK, this is superb. And there's some crossover with the next area that we're going to look at, which is training of staff. But Participant 4, you had your hand up next and then we'll come to Participant 1.

**Participant 4:** I think you're right that the ethics and the code is all there. It's written out as the mission statement or what the values are, or whatever. But often there isn't the resource within the service. So yes, the board might be told that whatever's needed, but if there is then no resource and finance to then increase the staffing or allow more time for training, more time for reflective things, then it's very difficult for them then to enact it, even if they want to, with the best will in the world. And I guess maybe I'm being trying to be optimistic that actually they are trying to help, but actually their hands are a little bit tied.

And the other thing I was going to say is that I did recently meet with our ICB patient safety team and there is obviously some confusion about where medical examiners are going to sit, where they're going to report into, who's even going to long term employ us. And they don't as yet have a system for us to feed into them. So actually with a lot of the primary care things, it's felt like I'm needing to lead how we're going to do it. Definitely in our locality. And I feel that it's kind of saying, well, me saying, "wouldn't it be a good idea if...?" And then people going, "yes, that's right. Yes, we'll do it that way then." And it's not necessarily ideal. But again, we need a database so that we can feed into the ICB with all themes. Really.

**Professor Emma Cave:** Brilliant. Thank you. And Participant 1? Thank you.

**Participant 1:** Yes, I think it just sort of picks up a bit on Participant 6's point and also Participant 4's point. And this is just a personal opinion that I've gained over the 18 months of working with the ICBs. And when the ICBs were set up, well the ICSs as they were before, there were very clear about what

their function was specifically - I'm talking in terms of workforce. However, when they decided what their remit was, a lot of other things came their way that they weren't prepared for and weren't expecting. So what they were advertised to be then got really quite misshapen. So it's the old adage you know, “doing more with less”. And everybody's feeling the financial squeeze. They certainly are. And there's another whole round of restructures. Obviously we've had one from, as it was then, Health Education England, NHS England, and another recent reorganisation in November. So I guess what I'm saying is, I think it can be very difficult for the ICBs and ICSs to really carve and create their own footprint in the space when it's constantly changing, and what they're set up for and the understanding that people hold around their roles, changes as well. I think if that is steadied then they can really get some ground, but I think at the moment it feels a little ill-conceived around just letting them do what they were supposed to do without changing it every 5 minutes. It's just again, it's an observation for me. It's just my personal opinion, but I think they can do great things if the ground stands still long enough.

**Professor Emma Cave:** OK. Thank you, Participant 1. Participant 7, I just wondered whether you wanted to come in with anything on this. No problem if not.

**Participant 7:** I'm so sorry, I heard Participant 1 answer, but I didn't hear the full question.

**Professor Emma Cave:** OK. So what we're doing is we're looking at the common code of ethics, and we're thinking about the governance, really, of managers and whether the common code of ethics is enough. And we've heard the view that there is a code there so that they've done what was promised there, but too often it's ignored. Usually the will is there, but there are various constraints on being able to comply with it.

**Participant 7:** I mean from a social care perspective, which is probably not the - obviously the code isn’t aimed at social care - I suppose I would always say that in my experience the drivers in health and social care were very similar, but the levers are very different. So the fact that social care is so dispersed: 18,000 organisations more than 150 local authorities, 42 ICSs. Often the bit that we don't think about enough is implementation. And we think that, like weight loss, we hope that it's going to be hard to understand but easy to do. And actually, easy to understand, hard to do. And it requires a kind of sustained pooling of all of the levers and all of the different incentives leading in the same direction. And so I think just telling people - you know, never in the history of organisations or cultures has just telling people what to do been enough. So it's about how we, at every stage, from a social care perspective, how we support people to have the knowledge, how we incentivise, how we prevent and then how we detect and then how we mitigate. And they all require slightly different things. And a code of ethics can do a little bit of that at the beginning in terms of prevention. It's not going to do the detection. It's not going to do the mitigation. And then at the heart, I think there's something to talk about probably a later conversation, when we think about the incentives and social care and how they sometimes are driving, there's sometimes perverse incentives, and we don't have those set up in the right way. But that's a bit more of a paradigm shift.

If I were to look at all the evidence that we have and what makes most difference in terms of in organisations and organisational cultures, it's your registered manager in social care of which there's about 23,500. So that's a group that we can get our arms around, you know, it's not the 1.5 million in the broader workforce. And then we've got about 5% of the workforce that are regulated professionals and hold the professional standards and human rights approach and the ethics. And I think sometimes we don't talk enough about that quite small, but very mighty, part of the workforce.

**Professor Emma Cave:** Fabulous. Thank you, some very important comments there. OK. So again, we're running a little behind in terms of where we are for the things that we have to cover. But I do want to

hear what everybody has to say. So if I could just ask if you could keep it fairly succinct, and then we can move on to the next area. So Participant 3, you're first.

**Participant 3:** Yes, I just want to come in on the fact of, 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". And I think that shift in where we put our marker down and when we put our marker down, is difficult. It shouldn't be. Again, it's one of these things that you feel like it should be saying, "this is how it is, how it should operate. This is easy to put in place. We all agree with it". But seeing that play out in reality, it definitely doesn't look like that.

**Professor Emma Cave:** Yes, good point. OK, so Participant 2.

**Participant 2:** So my reflection was just when we talk about the manager's code of ethics. So when I started in the NHS, my first job as a manager, I was given the Code of Ethics for NHS managers from 2002 and it hasn't been updated since. And I had to remind myself, where is it? When was the last time I looked at it? And so I think, we get promoted. So you've gone from Band whatever it is, and then someone attaches 'manager' to your title. Who's taught me how to be one? Alright, so my example is the manager that I've got. And so if their behaviour, attitudes are toxic, then I think that's what's normal. And I pass that on. And so if we don't constantly review, measure, talk about, reflect on that, what's happening there?

I think also there's been manager-bashing a lot. So if it goes wrong, blame the manager. Rather than, how do we use this group of people who do have influence, to shape how services run, and teams? How are we going to support them to be better? Where did we show them what better looks like? How did we support, train, equip them to do those jobs? So I think if just, putting a code of ethics is fine, what's the system to support people to thrive around that?

And we usually wait till somebody breaks before we think about, what system do we need to put in place to help them to thrive? So I think for me it's more than just having a code of ethics. There's a whole system and culture around what's acceptable and what's not. Because actually in reality, the last worst behaviour that we've tolerated becomes the norm. And I'd love to say that was mine, I heard that. I think it was John Amaechi's webinar who said that. So yes, that's it.

**Professor Emma Cave:** I'm getting a really strong sense that the code is all very well, but it's not enough, it needs so much behind it. Participant 4?

**Participant 4:** I wanted to talk about the constraints of the code and the fact that it's very difficult to implement if you're working in a completely stressed overwhelmed system, which is where we are. And I know it's the same in social care, definitely the same every day on the wards, in the GP surgeries, in the emergency departments. And the fact is, it is completely interlinked with social care because part of the hospital overwhelm is because there just is no flow and so people can't come out the hospital, so therefore every member of staff that's working in that environment is completely overwhelmed. So they may want to adhere to the Code of Ethics, but if you are completely overwhelmed and stressed, that is very difficult for people to do.

**Professor Emma Cave:** Point well taken. Thank you. OK. We're going to move on now to training of staff, which is our second of the three areas. And so there's only one recommendation that we're going to look at here. So this is a little shorter to deal with. It relates to training on collaborative leadership and organisational values so there's quite a lot of overlap with what we've just been discussing.

So the recommendation is, and it comes from the Health and Social Care Review 2022, so it's very recent: “Targeted interventions on collaborative leadership and organisational values, including a new national entry-level induction for all who join health and social care.” So this is very important that we think about this from across health and social care. So in your experience, do all staff across health and social care receive effective training on collaborative leadership and organisational values? Take it away. So got the hands up already. I presume this relates to this question, but it doesn't matter because there is quite a lot of overlap with the last one. But Participant 1, you start us off.

**Participant 1:** I don't know. There was a hand up before me. Have you retracted, Participant 2?

**Professor Emma Cave:** According to my system, you’re number one.

**Participant 1:** Oh, that's OK. I'm quite happy to go ahead. I always get a little bit nervous, and I'm sure this isn't just you framing the question, when people say, “oh, is training effective?”. Because training is a delivery mechanism for skill and knowledge and information. And you could have the most fantastic training resource, trainer and materials, it doesn't in itself make it effective. What makes it effective is the measurement of it and the purpose of the training, being able to see the impact of that.

So it's sort of not an easy answer to give, but there's two areas really. One is, it's not just the training, you need to look at it holistically. And for something that is so large, which takes a lot of culture change, a lot of historical change for the two sectors to come together, it needs to be signalled and mirrored in a number of places, not just on training. So the quick answer if you're going to do training in this area would be that you absolutely have to follow that up in your conversations, in your observations of practice, as part of an ongoing evaluation. Which would be, are you seeing that in somebody's practice? You're seeing that in somebody's notes? Are you hearing them reflect on collaboration in their conversations? Is it part of an induction? It needs to go through like a stick of rock in order to be effective. And then what is your measure of it?

The other part of it - and Participant 7 touched on it as well - in terms of the sheer enormity and diversity that is in social care means that there are small, medium and large, private, voluntary and independent sector of social care. There is also the local authority area of social care with social workers and OTs. In all of those aspects, you will have a number of training organisations and a number of owners and managers and registered managers. And unless they really embrace the first part of what I was saying about it being holistic, about not just a tick-box approach to training, “oh, that person gets it now”. It's much more to do with the follow up. And also for them to think about their understanding of collaborative leadership and organisational values before they receive the training. And then again for that mirror: what does the culture of the organisation reflect? Is that something that all managers buy into? Because managers’ power is very, very effective in terms of their influence of the staff. So not a very succinct answer, but that's my immediate response to that question. I hope that's useful.

**Professor Emma Cave:** No, it certainly is useful. I suppose the nature of our evaluation is we're trying to be as specific as we can about things that the government promised to do. So it's very useful to think about that context, but we also do need to think about well, is there a national entry level induction, is it working? Is it the same for everybody? Is it inconsistent? So thinking about that as well as the context within which it sits. Participant 6?

**Participant 6:** And I think that's a good way of reframing it because I entirely agree with what Participant 1 said about training delivered does not mean impact and improvement. And if you want to really hide something, you stick it in the induction. Participant 4 and I have both been involved in induction where you sit there and staff, they've had all sorts of things thrown at them, so they get a list of stuff thrown at them. Equality, diversity, health and safety, how to do a blood gas, "oh by the way, meet the medical examiner". And it just goes on. And I'm entirely sure that that's mimicked across all the organisations Participant 1 described. Because we're not actually very good at inductive training and we're not very good at keeping it alive and bringing into that training the voice of the service users and making it actually real. So it becomes a tick list approach.

And the worry for me is that if we do what has been suggested, that we will just introduce a tick list that goes across all these organisations, but it's not impactful. And that's not easy and we're coming back to Participant 4's talk about resources. But it's so integral to culture and behaviours that, actually what we're talking about is not training at all, what we're talking about is shared culture. And you can introduce training, but actually cultural change is at least three years. To move behaviour is really quite a difficult thing to do, and it needs constant reinforcement in the workplace.

So for anybody who's a service deliverer, it doesn't matter whether you have social care background or medical or nursing background, actually, it's that constant reinforcement of: "this is the standard. This is the standard". And it's like teaching your kids not to swear or to eat their peas. It is constant reinforcement. And you've all got to be the same, so you can't have good parent-bad parent and you can't have soft manager-hard manager. No, "this is the way we do things here". And it becomes what - I think is that a Yorkshire tea advert: "This is how we do it here"? And it needs to be constant and it's board-down and it is bottom-up. And it is really, really hard work when you're under stress and everybody's kind of snapping. And we know that there's a real impact of that kind of discourtesy. But it all stems from we're too tired to keep the standards up. And it's really difficult to get the impact that Participant 1 is after.

So we've going to be very careful what we're asking for in that request, Emma, because it's easy to say, "yeah, we've done that. We've done the training, we've done the training, they have been trained". And beyond that we can just criticise them. That's my worry about it.

**Professor Emma Cave:** Thank you. That's all so important. Participant 7?

**Participant 7:** Thank you. So this is definitely in my wheelhouse. I feel like I can contribute to this one. 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. But we've also got the Care Certificate which is being launched as a Level 2 qualification with government funding behind it, and that will help in terms of the knowledge element of induction. But of course the knowledge element is only one part, which goes back to Participant 6's point. And when we look at our turnover, we lose half of our staff in the first six months. We lose one in two younger people. Over the year, turnover is lower, it's about 30%. But we lose them quite quickly and then it starts to reduce. And that does indicate a poor induction and a lack of understanding of the roles. So we're definitely not doing something right.

In terms of our collaborative leadership, I'll just make two points and then I'll let somebody else come in, but we did some work with our registered managers in terms of what works with learning. And three things need to be in place: learning input, a peer network to help them work through what this means, and an organisation that allows them to implement the changes. And if you don't have all three of those things, then it's much less likely to have a have an impact.

And then when we look at social care's ability to be around those tables, in terms of collaborative leadership, I'll often - it's great to have Participant 1 here - I'll often turn up to meetings and I'll be one social care voice among fifteen health voices, and I love that, I'm happy with that. But it's more difficult to have those collaborative conversations when social care is only spoken about as part of the problem, or *the* problem to be solved as an adjunct to the NHS, or an escape valve to the NHS. Once social care was seen as a source of solutions: experts on prevention, experts on personalisation, experts on well-being; that will be really helpful because we'll be coming in as equals.

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.

**Professor Emma Cave:** Gosh Participant 7, there's an awful lot in there. Thank you very much. Look forward to unpacking that. Participant 3?

**Participant 3:** I just wanted to come back to it to Participant 6's point as well about how - I think our staff survey data probably says across providers that over 90% of employees could list their trust values. I don't think people have a problem listing what they might stand for. But then we've got an average of over 20% who say they've been bullied at work. And so if we're looking at whether it's working, if you can list the values but you've got a significant difference in your staff that are having bullying from managers or colleagues then we obviously know that that's not working across the board, it's not being rolled out in the same way. And I think when you've got registered professionals who are held to account with different codes of practice and what becomes acceptable, what the GMC [General Medical Council] will expect or allow compared to the HCPC [Health and Care Professions Council], where is the level? Because it doesn't feel consistent either how maybe a nurse will be treated, to a physio, to a radiographer to, you know. And I think with that lack of clarity as well, that I could behave in a certain way that would then be unacceptable for Participant 4 to do for example, doesn't help with us reiterating what is acceptable, and how we're embedding what we are expecting of people.

**Professor Emma Cave:** Thank you, everybody. Given us an awful lot to think about on that particular recommendation. Last part, and we've made up a little time now so we're doing alright for the last 25 minutes. Oh first, does anybody want a break? Does anybody want 5 minutes just to take some time? Yes. You want to go and fill up your teacup, right? Let's just have 5 minutes. And if you just turn your cameras off, don't leave the call. If anybody wants to go fill up a cup of tea, we'll see you in 5.

Welcome back. Thank you. Great. Just give it another minute or so. Wait for everybody. OK, that's marvellous. OK. Thank you. Right.

So, in the final section, we're going to look at the culture of safety and particularly at whistleblowing. Two recommendations. We know, of course, that notwithstanding many, many changes over the years, this has been a very persistent issue. So the first of the two recommendations we're focusing on comes from Freedom to Speak Up, and it calls for every organisation to actively foster a culture of safety and learning in which all staff can raise concerns.

So the question is, from your point of view, how effectively do NHS organisations ensure that staff feel safe to raise concerns? And could we please start with you, Participant 5?

**Participant 5:** OK. Thank you. Well, I suppose my opinion here might not reflect everybody's. But I really don't feel that there has been any progress made over the years. Obviously I've published on the matter and my case has been fairly well known, and I get a constant stream of emails and messages from NHS staff who are frightened about speaking up or who have been targeted after doing so. So I guess we're

going to go on to things like the Freedom to Speak Up initiative and so on, which I think is very well-meaning and was started with all the right intentions, but which I think really hasn't had the power to really deal with this ingrained issue of targeting of whistleblowers. 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 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.

**Professor Emma Cave:** Thanks Participant 5. Who is it that sees whistleblowers as traitors and anti-NHS? Is it across the board? Is it a particular issue at certain levels?

**Participant 5:** I think that there's such an emphasis on reputation management, isn't there, in the NHS? And I think this comes right from the very, very top, that boards and senior managers are expected to keep the lid on any potential scandals. And I think in my case in Morecambe Bay that was particularly acute, because we'd just come out of the midwifery scandal and there was a sense when I was speaking up that, "we can't possibly have this all over again". 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 midwifery scandal". So I think basically reputation management trumps everything.

**Professor Emma Cave:** OK. Thank you, Participant 5. Would anybody else like to come in on this? And particularly, we want to think about the impact that this recommendation has had, whether it's had an impact on staff on patients within the NHS and how that might differ. Whether it's been appropriately funded. Whether there are differences across sectors. Great. Participant 3. Oh that's got lots of hands up.

**Participant 3:** I have a couple of points. I think that from the Freedom to Speak Up perspective, it's not got funding or it's not at the same level. So the banding or the seniority of the 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.

I also think people's experiences of speaking up is very varied depending on their profession as well. And I totally hear what Participant 5 is saying and, what do we read about in the newspapers? It tends to be consultants, doesn't it, that we're seeing, that have had some of the most horrific experiences which are being shared. I also think it's not the same for all staff and I think how staff are treated as differently throughout that speaking up process too. So I still think there's a vast variability in how that is and it is landing.

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.

**Professor Emma Cave:** OK. Thank you. Participant 2.

**Participant 2:** So just jumping on the back of what Participant 3 has said, the inconsistency in how people experience Freedom to Speak Up is concerning because actually we do have a universal job description for a Freedom to Speak Up Guardian, but no one considered what that ought to be in terms of banding. So if you give that role to somebody who is then perceived to be quite junior by certain members of staff, so they won't come to the Freedom to Speak Up Guardian because they feel that person is too far down. And that could be banding, but it could also be how that role is, you know, perceived and or, you know, marketed as a word I'm trying to use. So I think what significance is attached to the importance of having a Freedom to Speak Up Guardian, does greatly impact on how that is then received. I think that we have achieved a lot, but does this answer the question of creating a culture of safety? That is an unfair expectation of a single Guardian. So there is a perception that, "we've got a Guardian, we are saved". No, the responsibility for Freedom to Speak Up is actually everybody's. And how good a job are we doing of making sure everybody understands that in the same way as if it's safety, if it's, whatever the values are in the organisation, they're owned and ought to be delivered by everyone in that organisation. From my personal experience, having lots of people talking about things or issues is really good because it means that people do feel safe to raise concerns.

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?". And that for me is where unfortunately some of the headlines we have seen do our service damage because it says… So [a nurse] just went to tribunal because she's experienced racism and she did speak up and had to go to tribunal in order to have some resolution. That's really sad. Because actually there were steps all along her journey where we don't have a good enough culture of listening up.

Because we talk a lot about speaking up, but we don't do enough to train people to have that expectation of, if you are in a position of leadership, listening up is part of your job. It is your role to make sure that people know that you are approachable, and when people raise it, welcome it, don't see it as a threat to your personal kingdom. It's an alert to say "here's something that we need to focus our attention on". So I think there needs to be a balance of attention of speaking up, but also listening and creating the environment where we can actually do that. Because it's really difficult when people are tired, broken you know. So it's just the whole thing about, just because you've got a Guardian… But in a system where everybody's burned out and tired, no one's listening.

**Professor Emma Cave:** Thank you. That's really important. Participant 5, did you want to come back in on that?

**Participant 5:** I think I would just say that it's more than just not listening. We probably ought to address the issue as well of the retaliation that often happens to whistleblowers. So if I just hadn't been listened to but had kept my job, I'd probably be quite happy now looking back. But there is a terrible issue within the NHS of retaliation against whistleblowers, and it comes from colleagues, and it comes from managers, and it often involves multiple referrals to the regulator and so on. So there's a lot more to the psychology of whistleblowing in the response to it than just people sticking their fingers in their ears and not listening to what's going on.

**Professor Emma Cave:** OK, thank you. Participant 4.

**Participant 4:** I was just going to talk a little bit about how it is for us in primary care. 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 Participant 5 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.

**Professor Emma Cave:** OK thank you, Participant 4. It's a really important perspective. Recommendation two in this section deals with primary care. So we might have time just to come back to that briefly and look a little further at it, but that was great. Thank you. Participant 1. Sorry. I beg your pardon, we’ve just got until quarter to. So I would like to leave just doing a couple of minutes to deal with primary care. So again, if we could just be succinct with these last couple of comments, I'd really appreciate it. Thank you.

**Participant 1:** I think Participant 6 was before me.

**Participant 6:** All right. Thanks, Participant 1. I was going to just bring up the impact of our, what we used to call HR. So human resources, which is such a misnomer. But the human resource response, mediation is not a response to whistleblowing, and yet it's used all the time.

So there is something about that that is, as Participant 2 says, it's the listening. And we're back to, well, you’ve trained but what's the impact? And it's exactly the same theme coming through that Participant 1 mentioned before: you've got a policy, but what's the impact? How are people trained to raise a concern? Well, you're not, you're not. Nobody tells you how to gather evidence and make it coherent. And then how are people trained to respond to those concerns? Because you're absolutely right, if you've got a low-level Freedom Ambassador, then they're not going to be listened to, so it becomes self-fulfilling. And that coordinated systematic response of listening to the intellectual intelligence of an organisation is really very poor in the NHS and social care. Whereas if you go to a car manufacturer, anybody in the production line can pull the cord and stop the line because something is going wrong. So how do you do that in the NHS? That's very difficult indeed. But the processes of acting and impact I think is where the gap lies.

**Professor Emma Cave:** OK, sorry, I got the order wrong there. Participant 1, go ahead.

**Participant 1:** Thanks. I don't know much about the NHS, but I do know a bit about social care. And we always used to cover, in our local authority training, we used to cover whistleblowing in our safeguarding and go through how to raise a concern, both as a named person and if you wanted to whistleblow anonymously, and ways to do that. So I don't know whether there is anything like that or those things could be replicated in the NHS.

But there does seem to be a link here to psychological safety and also - just having Participant 5 on the call - it's not safe to do so. And when you've got family to feed and cost of living and, you know, you're just not going to do it. So there's staff wellbeing in there as well. So it factors in a lots of different things. So that's just what I wanted to say.

**Professor Emma Cave:** OK. Thank you very much. Alright, we're going to move on to the last recommendation now, which is about primary care. It requires various measures to ensure that the Freedom to Speak Up principles apply in primary care too. I won't read the whole thing out because that would take us the full 5 minutes. The question then is: how would you describe the culture of safety and speaking up in primary care?

And Participant 4, you've already given us some really useful insights there about how it's possible to raise concerns, but there's less focus on actually following up on them. So I just wondered if you or anybody else wanted to add anything else about primary care specifically?

**Participant 4:** 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.

**Professor Emma Cave:** Thank you. That's true, I suppose. When you add in dentistry and community pharmacy, that makes it even more complex. Participant 2.

**Participant 2:** So I think mine is linked to what Participant 4 was talking about in terms of different types of organisations. Primary care organisations are independent businesses. So a lot of them can be small. So if I'm a receptionist and the practice manager and the GP are married and now I've got to raise a concern, and they find out, I could be terminated. There is nothing to protect me.

So in the same vein as what Participant 5 was talking about how the NHS treats… the retaliation. And it is amplified significantly for people who are in much smaller settings where the protections that we have are just not there. There isn't the same level of safety. So how that's created is a concern for me.

So if you appoint a Freedom to Speak Up Guardian, is it at practice level, is it PCN [Primary Care Network] level? And even then, I'm not sure the safety is there. Because it might be that you're from a different practice, but then there's the, "well what right do you have? What's the escalation process? And what happens next?" And that's a difficult one to manage. So I think the boundaries of what we can do…

What would be helpful is to have a framework that says, "this is what will support those that do raise concerns". And perhaps having an independent body where they do that, maybe something to look at? But that body needs to be given the power to do something. So equally if CQC [Care Quality Commission] has a concern, they can go into practice and inspect it. So something similar would be helpful.

**Professor Emma Cave:** That's really fabulous. Thank you, Participant 2 what a brilliant suggestion. OK. We're going to be called in in just a couple of minutes, so I very quickly want to say thank you so much. Jane is going to add her thanks well, but that has been such a rich discussion and so beneficial for us in the last couple of minutes. Does anybody want to add anything else?

**Participant 5:** Could I just actually follow up on something that Participant 2 said there, which was about power, wasn't it? I think, and I do think there's a lot of well-meaning people out there who want to help whistleblowers and who want to promote whistleblowing and who see the benefits of it. The trouble is, there's such a power imbalance between those who want to promote whistleblowing and Freedom to Speak Up and safeguarding, and those who have a vested interest in closing it down. So that's all I wanted to say. Thank you.

**Professor Emma Cave:** Thanks very much, Participant 5. Does anybody else want to add anything?

**Participant 2:** So just very quickly, there wasn't a question necessarily about this, but I think one of the barriers to speaking up can also be people with 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 et cetera 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.

**Professor Emma Cave:** Thank you. That's very important. Participant 1?

**Participant 1:** Thank you. We're seeing something very similar at the moment with international recruits in social care, so really. But whistleblowing is such a big-ticket item right now. Just in general, just thank you very much for putting this event on and giving us the opportunity to reflect on this and hearing our voices. I've just wanted to say thank you.

**Professor Emma Cave:** Well, the honour is all ours. Thank you. And Participant 6?

**Participant 6:** And the only thing that I would add is that sometimes whistleblowers are actually wrong because they haven't got context, they haven't got all the detail, but that should be addressed with data and a proper rebuttal, not blaming, barriers and treat the individual as some kind of leper. It's about well actually, "I hear you and here's the evidence that you might not be correct. Can you help us take this forward?". And it's that inclusion of the whistleblower that's absolutely lacking. And then, yes, Participant 1, I would absolutely agree. This has been a fascinating conversation. You are really interesting. And if it were possible, we should all go to the pub because the conversation today has been absolutely fantastic.

**Professor Emma Cave:** Wouldn't that be nice.

**Participant 6:** I would like that.

**Professor Emma Cave:** We're going to be called back any minute, I think, but it's just past quarter two, so it's not happened yet, so we can keep chatting.

**Moderator:** Yes, sorry. I put a note in the chat. We have a little bit of extra time. Because I think one of the other groups has run over a little bit. So if there's anything else that we want to discuss, you have a few more minutes.

**Professor Emma Cave:** I'm sorry, I don't know why I can't see the chat.

**Participant 1:** I can't either.

**Moderator:** Apologies.

**Participant 1:** I was just going to come back on Participant 6's point. Actually, one of the things that just reminded me when we were delivering training on the safeguarding, that it's much better to have an unsubstantiated alert than not to get the alert at all. And I think it's really important. Because you're absolutely right, Participant 6, it's sometimes people do get it wrong. And the handling of that is really important. Because if it's handled incorrectly, then it doesn't do, it's not positive signalling that it's still good practice to raise these things even if you're wrong, because you're active in that and safeguarding is everybody's business. Whistleblowing is everybody's business. So I just want you to say that.

**Professor Emma Cave:** Yes, good point. Participant 4?

**Participant 4:** I was just going to say I've had an example of that this morning in that something had been raised, family had raised something, we'd looked into it, to a certain extent, as the medical examiner service, which is our role. We couldn't find the evidence to reassure the family so it was referred back in. And then it's come back from this as if, "maybe that shouldn't have been referred because the facts weren't quite correct". But actually they've done their job correctly. And that's why I've gone back to say actually, "thank you so much for looking into it. That's exactly what should have happened. Well done. And yes, that's fine that it wasn't correct. And now we can let the family know and they can be reassured. That's the whole point." Whereas it felt a little bit like their response was, "you shouldn't have told us". It's that sort of trying to change the attitude of, just because we refer something doesn't mean it's automatically that you've done something wrong. Because it doesn't mean that at all.

**Professor Emma Cave:** OK, so there are plenty of examples of the opposite happening then, of people being told "you shouldn't have referred that" in a way that puts other people off, do you think?

**Participant 4:** I think it requires us to be robust. And I think over the years of doing this role, my skin has thickened to that. Yes. But I understand where they're coming from as well. They're coming from a point of, they're overwhelmed. They have so many things to try and do. If that was the only thing they've been given to do that day, to look into that, would be fine. But actually it's one of a huge number of jobs that they have to do. So that's where it's coming from. It's that the service is under-resourced, which I think have probably said. But yes, it's that and it's their stress and it's managing their stress to sort of say, "yes, it's OK. Thanks very much".

**Professor Emma Cave:** OK. Thank you. Any other comments?

**Participant 3:** I think it also does come back to what we've discussed before about power as well and how some people might be OK to raise something if they've got it wrong, if they feel secure and they're in a position where someone could say to them, "oh, that's not right", and they say, "OK that's fine because I feel secure and I feel happy and I feel supported and I feel safe in my environment to be able to get things wrong". But I think it came back to, right at the beginning Participant 6 when you said you can't talk about the NHS and then not being blamed because that's delusional. But that's definitely not people's experiences across the board. So I think if you don't feel safe in your role, you're not going to risk getting it maybe wrong. You're kind of all-in or you're not going in at all. And I think that's the problem where we'll miss things, because people aren't going to do those near-misses or the equivalent of that, of, "I'm not quite sure". So just a comment.

**Professor Emma Cave:** Thank you.

**Participant 2:** I think just, a thought that occurred to me was something that Participant 7 had mentioned about the discussions around social care being the problem rather than part of the solution. I think there's also something about reframing the role of the whistleblower as part of the solution. It's just an alert to say, "focus your attention" not somebody to be crucified.

**End of transcript**

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