Written evidence submitted by Group 2 (PSN0031)

Transcript of roundtable event with patient safety investigators and professional standards leaders 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 Dame Jane Dacre: If I may, both Stephen and I have already introduced ourselves. Could I again go round the screen? So first of all, Tom, if you would?

Tom Kark KC: Hello there. I'm Tom Kark. I'm a barrister. I was counsel to Sir Robert Francis' Mid Staffs inquiry and then in 2018 I was commissioned to write a report into the workings of the Fit and Proper Person Test, and I wrote a report and made some recommendations, which is why I expect I've been asked to be here.

Professor Dame Jane Dacre: And we're very grateful. Thank you very much. Christine Braithwaite?

Christine Braithwaite: Hello. I'm Christine Brathwaite, Director of Standards and Policy at the Professional Standards Authority. I'm standing in for Alan Clamp. Apologies Alan wasn't able to attend himself today, but I'm here in his stead.

Professor Dame Jane Dacre: Thank you. You're very welcome. Sam Foster?

Sam Foster: Hi, good afternoon. My name is Sam Foster, I'm the Executive Director for Professional Practice at the Nursing and Midwifery Council. I'm a registered nurse and I've been with the NMC for about nine months. Prior to that I was a Chief Nursing Officer in the NHS for 10 years.

Professor Dame Jane Dacre: Excellent. Thank you very much. Colin Melville?

Professor Colin Melville: Hi Jane. So, Colin Melville. I'm the Medical Director and Director of Education and Standards at the General Medical Council. Formerly a clinician. I'm still on the register I should add. I have quite a lot of experience in medical education and senior medical leadership.

Professor Dame Jane Dacre: Thank you, Colin. Bernie?

Dr Bernie Croal: Good afternoon. Hi. I'm Bernie Croal. I'm a chemical pathologist from Aberdeen and I'm the current President of RC Path [Royal College of Pathologists]. Thank you.

Professor Dame Jane Dacre: Thank you very much, Bernie. And Stephen you've met before. So, Stephen and I are going to be doing a little bit of a double act going through the conversation. Just to remind you, the conversation will be recorded and that is so that we can use the information to go into the report that we compile, that gets fed into the Health and Social Care Committee. So just as a starter, one of the things that, if I may, I want to ask you…. Oh sorry, Andrew have I left you out?

Andrew Smith: Yes, no problem at all.

Professor Dame Jane Dacre: My apologies, you didn't have the camera on, so I ignored you. I do apologise.

Andrew Smith: I'm Andrew Smith. I'm the Deputy Chief Executive and the Director for Education,

Registration and Policy and Standards at the Health and Care Professions Council. We regulate fifteen health and care professions across the UK.

Professor Dame Jane Dacre: Thank you. Have I left anybody else out? In fact, can everybody who's got their camera off just introduce yourself so that we know who the lurkers are?

Staff member: Hello. Yes, thank you. I work in the Select Committee Engagement Team for UK Parliament. I'm a new member of staff in the team so I'm here to observe proceedings. Thank you.

Staff member: Hello, I'm a senior specialist for the Health and Social Care Committee and I'll be leading the Committee's inquiry on NHS Leadership Performance and Patient Safety, so I'm just here to observe.

Professor Dame Jane Dacre: So [the senior specialist] is very important, because this is where our report will feed in. And Kath?

Professor Katherine Woolf: Hi, I'm Kath Woolf the Parliamentary Academic Fellow assigned to work with the Expert Panel, helping the panel write the report. So I'll be in the background as well listening in.

Professor Dame Jane Dacre: OK. Thank you very much. Now, as a sort of overview, one of the things that's come up in our background research and reading so far is that public inquiries and reviews often make recommendations to improve patient safety. And although the Government accepts these, when it comes down to it the recommendations are not always implemented very well. So, what we want to do is to ask you some questions about specific recommendations where we want to hear your views. And we'd like to know what your view is about how well or otherwise these recommendations have been viewed or implemented, if that's OK? So just to bear that in mind because the impression is that often very worthy and well-founded recommendations might spend a bit of time sitting on the shelf. Within the Expert Panel, we can't review every recommendation of every single inquiry. And so what we have done in the Core Panel is to select recommendations that reflect the whole area but also are pragmatic and reasonably easy to measure. So we take a bit of an eclectic sample of the recommendations that have been made across a very broad area. I'm going to ask Stephen to just come in here, in case there's anything you want to add in relation to how we've done that and what we're moving on to talk about?

Professor Stephen Peckham: Not really, thank you, Jane, except that we are interested in - has something been done? And perhaps why maybe something *hasn't* been done? So it is that, the failing of the mechanism between acceptance of a particular recommendation or policy and the fact that nothing has happened in practice. Or something happened in practice and we really want to know that linkage, and if there are issues around that that we ought to be feeding back. I think that's probably the only thing to add. And also we are particularly interested in your broader perspective on it; so whether you have particular individual views about this, then that's really welcome.

Professor Dame Jane Dacre: OK. Thank you. And the aim here is not to blame, but to diagnose and be supportive about how something can move on. The first of the recommendations that we've selected that we'd like to discuss is around the area of maternity care and leadership. And the recommendation is written out in your documentation. I don't know whether it would help if I just remind you? This is the recommendation: "There's 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 it's our view…" - this is the view of the inquiry,

which is the Morecambe Bay inquiry we're talking about here - “…that it is no less applicable to maternal and perinatal deaths and should have raised concerns in the University Hospitals 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.” Now that was in 2015. And the issue that we would like to discuss is medical examiners, first. And medical examiners’ extension into the areas of maternity safety, because that's where that recommendation is focused. So the first question, if I may, is how successful is the English system of medical examiners at identifying problems, but maybe specifically in maternal and perinatal deaths? I don't know who would like to start? Stephen, is there anything again that I need to add to clarify that while you're thinking about who's going to put their hand up to start? Welcome. Would you like to just introduce your yourself?

Dame Linda Pollard: It’s Linda Pollard. Dame Linda Pollard.

Professor Dame Jane Dacre: Perfect. That's great actually, because I think it's sooner than we thought. So that's wonderful. All right. So medical examiners. Nobody's actually put their hand up first, but I know, Bernie, that the Royal College of Pathologists has had an awful lot to do with the implementation of medical examiners. So would you mind starting and just giving us your view on how successful you think they've been? And also then to move on to the area of maternity safety?

Dr Bernie Croal: OK. Thanks. I mean my own personal knowledge about the medical examiner system is quite small. I mean, Suzy Lishman would have been the person to speak on this, but I take it she either wasn't invited or wasn't available. She's been leading the development of medical examiners. I mean certainly RC Path have been responsible over the last ten years or so, trying to push government to finally come in and fund the medical examiner system in England. And that finally happened. And we've been very successfully training a large number of medical examiners now who are at that point where they can start to do good stuff and fit into the system, in the way in which we envisaged. But in terms of the specifics around this topic I can't comment, sorry.

Professor Dame Jane Dacre: OK. Thank you very much. Sam, you had your hand up?

Sam Foster: Yes, just a couple of comments, but mainly from my experience before the NMC.

Professor Dame Jane Dacre: You are [all] here because you have expertise, so don't worry about representing your organisation.

Sam Foster: I've worked in one organisation that was an early adopter and one that was slightly later. Funding was often a bit of a disabler, particularly the infrastructure around supporting medical examiners. We spent a long time getting a business case to move what was bereavement officers into an MEO [Medical Examiner Officer] role, get the training organised and get the infrastructure around the medical examiners. So, in my experience, there’s a quite varied approach: from kind of on a shoestring to really, really robust MEOs with an infrastructure to support. As the Board Safety Champion for maternity and neonates, there's still quite a closed culture in my experience… We do a peer review, MDT [multidisciplinary team] perinatal mortality review, so when there's a big caseload of things to review, often the teams would say “it's OK, we'll go through our processes, we'll let you know”. So I think there are still closed cultures within neonatologists and that wider MDT. I think in terms of where maternity services sit, particularly in large organisations, they get a bit subsumed into wider divisional governance. And then what happens is you've got really detailed reports going to Trust Boards. And my Board found it quite overwhelming the amount of maternity information

that we had to bring through to meet the Maternity Incentive Scheme. And it really became something that they knew was for noting but really struggled to interpret. It came to Confidential Board because it was potentially identifiable, but I don't believe that we have the right conversations at Board level. They were wholly reliant on the clinicians flagging if there was something outwith. So there is potential for it to work very well, but it's quite dependent on local governance situations and there's obviously going to be lots to learn from the Thirlwall Inquiry as well around governance in this area.

Professor Dame Jane Dacre: OK. Thank you very much. Does anybody else want to come in on medical examiners? So there's just a wrinkle in the system that certainly, in my background reading, is about whether medical examiners were originally designed for adults. And I don't know whether people have a view about the recommendation that suggests that they ought to be extended to the area of neonatal medicine. Does anybody have a view? I think there's something about coroners and whether or not coroners get involved. Colin?

Professor Colin Melville: Well, just on the background reading, Jane, to my understanding, the coronial side of it sits with the local authority. And what we're trying to tackle here is a mixture of things which happened within public health services and things which are happening, say, outside that, which sits somewhere else. The medical examiner objective feels sound to me, but I'm wondering whether it's how it's implemented that's creating - so setting aside money, because everyone will always say there's a money issue - it's a clarity about who is overseeing it, you know, which authority? Is it NHS or local government? Something about primary and secondary care, so that both are captured. And then, to the point that I think you just made, there is in my mind - Bernie may have a different view - but in my mind there is a wholly different approach to adult death in terms of its interpretation and maternity, perinatal, paediatric. So a simple system of medical examiners would need to be subdivided in some way so that you had a paediatric component and adult component, etc. And I wonder whether we trip ourselves up in simple statements, that the implementation of which becomes more complex. And I don't know whether that's come up. I don't do clinical practice anymore as you probably know, so I don't feel in a position to comment on it from a personal… But that was my understanding of reading around it, but also having listened to what others have said, that maybe it's in the stratification of the process, and clarity about where it sits, that may be slowing down what is otherwise inevitably an important approach.

Professor Dame Jane Dacre: Thank you. I mean the whole implementation of medical examiners has taken an awfully long time, because they were first mooted after the Shipman deaths. I don't know whether anybody has a comment on that? Anybody have a view about why it might have taken so long and whether it should have taken so long? Because it does seem to have been a labyrinthine and very difficult task to get done. I mean I think it's just about done now, but it's taken an awfully long time. Any views? Bernie?

Dr Bernie Croal: Yeah, certainly RC Path began discussions with Government from 2013-14 onwards, and Suzy Lishman, who then became President [of RC Path] just around that time, was very instrumental in pushing that, but got absolutely nowhere. And the block was with the Health Secretary at the time who didn't provide the funding to allow the training to take place and to be developed by RC Path. That training and funding didn't come until much later on - 2019 I think. And since then, we've trained 1,500 medical examiners and some more are coming through the system now. The blockage was around funding from Government and nothing else as far as I'm aware.

Professor Dame Jane Dacre: OK. Thank you. Anybody else have any views on the blockage and the length of time? Yes, Sam?

Sam Foster: I think there were some early adopters that we were obviously watching who were going to develop future ways of working. So that wasn't necessarily a blocker, but that was something that people watched and waited for. And then there was lots of opportunities for people to share their relevant business cases. I know, we don't like to hear it, but we did have to put business cases for investment forward to invest in the infrastructure and the payment of the sessions. There was lots of argy-bargy around funding sessions for clinicians to undertake it. On a really positive note, there is so much positive feedback from families and the conversations that they have with the medical examiners, of having that opportunity to ask questions and really support their grieving process. And prevent them from having to enter into other processes to find the answers that they need. So that there is a wealth of really, really positive patient and carer experience that has come out of these roles.

Professor Dame Jane Dacre: Thank you. Would anybody else like to add anything about medical examiners? Specifically, perhaps, relating to the barriers of implementation or the impact that they've had? Colin?

Professor Colin Melville: It was just to say there may be another angle to this, which is something we've been looking at, which is not just about the individual medical examiner and the involvement in the individual case, but how we join the dots and create the picture that allows us to intervene in a timely way. I'll come back to that if you want, but I did have a comment on that aspect of it.

Professor Dame Jane Dacre: Please go ahead.

Professor Colin Melville: Well, it was only to say that we've had some discussions between ourselves, NMC and CQC on data pooling, so that we understand some of the things around for example FTP [fitness to practise] and concerns. And we've now got a joint data pool in place, so it allows us to join the dots between issues that are raised in individual organisations. I appreciate that's a little bit, you could argue, 'horse and stable door', but I think one of the problems is actually joining the stories together. And I guess that was part of the question that was asked potentially around the Lucy Letby story. You know, it's not the individual cases, it's what made the whole pattern, and the whole story. So that's something that's now in place. We started I think in 2022 - I think it was in 2022 - and it's now in place. So it hasn't led to anything, but it does mean we've got a joined up approach across several regulators.

Professor Dame Jane Dacre: Thank you. Can I ask members who haven't yet…. Great, thank you, Christine.

Christine Braithwaite: Thank you. I don't have direct knowledge or experience of the medical examiner system, so I can't talk directly to that. But I am just thinking, how would it have been noticed that the medical examiner recommendation hadn't been implemented for a long time. As you know, one of the issues with enquiries is whether or not recommendations are implemented going forward. So how might it have been spotted? I was thinking in the days when I was with the Healthcare Commission, they had at one point and mortality outlier programme. So they routinely would monitor that. And that would obviously have flagged up Trusts who appeared to be outliers, but also potentially prompted questions about deaths that were occurring. Which might then have led to the discovery, that cases weren't being reviewed in that way. So having that connection between an inspectorate and a recommendation, I think is quite helpful for flagging whether something is being implemented in early stage and then discovering what the blocks are to it being implemented, if it's not being.

Professor Dame Jane Dacre: Thank you. Andrew. And then Linda.

Andrew Smith: Thanks. I suppose on this particular theme, I don't feel like I have a very detailed expertise. Sam and Colin would be much better placed than I am. The professionals we regulate may be involved in maternity care to a certain extent, but very much on the margins. So I don't have a huge amount to add on this theme. It may come up more under whistleblowing, I suppose. From a Healthcare Professions Council point of view, and we've recently been signing up to what we call the 'merging concerns protocols', which I think the other regulators have all been doing. I think that goes to Colin's points about how you join the dots and actually get the early warning signs or something going wrong. And as regulators coming together and trying to, as much as possible, get ahead of issues. It's probably more relevant to the whistleblowing theme so I can come back to it there if that would be helpful.

Professor Dame Jane Dacre: Thank you very much. Linda.

Dame Linda Pollard: It was just on the last point because, certainly the medical side I'm not professionally qualified to be able to make a comment. But certainly on processes, the outlier situation, just in my own Trust we have the largest paediatric and neonatal, the whole kind of maternity spectrum, we have here at Leeds. But the protocols that are so embedded, that go through the governance system for a Trust, the outliers would absolutely be identified. And we are regularly because we're a major trauma centre. So even outside of maternity, in this particular case, it would be highlighted immediately, and then it literally goes to the Senior Management Group that then feeds straight into the Quality Committee and they would deep dive it. In fact, they would deep dive regularly. And then it comes straight into Board. Board would immediately know about that and we review that about every quarter. And this is all fed back to our regulators as well. But if the committee structure and the governance structure is not working - and I was very conscious of what Sam said earlier, which was pretty disappointing in my view, and I think there will be things coming out of the Letby Inquiry particularly that will look at and I'm sure highlight exactly where you've just come through, Sam - but if governance systems are working properly within a Trust, that should absolutely be identified very early doors. I'd be very disappointed in my particular Trust if I got to the point of the whistleblower. Yes, it can happen. You know, we have 22,000 people in our Trust. Things will happen. But I would be very, very disappointed if that came through that source and not the regulated source that should be in every Trust, quite frankly.

Professor Dame Jane Dacre: Thank you. Sam?

Sam Foster: Yes, just to reiterate, I think that the M&M [Morbidity and Mortality] structure, that line of sight from Board to ward is pretty robust in the majority of organisations. Less so in those that are CQC Inadequates or that the Well-Led [review framework] has flagged. CQC also provided that additional questions asked. When Doctor Foster showed an outlier we had a requirement to report to the CQC, as you say. Going back to the recommendations from inquiries, that becomes more of a bit of a legacy document. So organisations will tend to have an inquiry actions log, where we'll routinely relook at what are the recommendations and where are they in train, from various national inquiries. And there will be a tracker against that. But the morbidity and mortality line of sight is much more live and routine, going through internal governance and up to Board. But the recommendations such as implementation of medical examiners, there'll be a descriptor, but if the Board's content with that, i.e. we're waiting for the early adopter to come out with or we've got a bid in, then, if the Board is content with the progress of that, that's where that will sit. But the majority will have a kind of inquiries log.

Professor Dame Jane Dacre: Thank you. Tom, you're sitting there looking awfully thoughtful. And I was wondering whether I could just ask you your view at a high level on what you think about the implementation of medical examiners?

Tom Kark KC: I don't think I can comment on that specifically. I don't have any direct knowledge. But the only thing that I would say is as a report writer, trying to follow one's own recommendations and where they are in terms of implementation, is astonishingly difficult. Because very often I find – I've only been involved in a couple of times - but you write a report, it goes out into the ether, the Government Minister says "thank you very much", and you may hear very little after that. I was actually eventually contacted, I can't remember, but nine months later, maybe a year later, and I may have had three meetings. I think one thing that would help would be to have a key point of contact, perhaps in the Department, whose responsibility is to keep the report writer up to date and to get some input. Because otherwise, as I say it, it goes into the ether and you might never hear of it again.

Professor Dame Jane Dacre: That's certainly Robert Francis' concern with his report, as you know, because -

Tom Kark KC: Where he had more recommendations than me. Yes.

Professor Dame Jane Dacre: He had hundreds and hundreds of recommendations, didn't he. Sam, is your hand up again? I'm not saying that in a bad way. In a good way.

Sam Foster: I just had another moment of…. If a recommendation is anchored into something that we have a timescale for then it makes it probably easier to deliver.
So I'm pretty sure that implementation of a template or of a model for perinatal mortality, is in the Maternity Incentive Scheme, where there is sign-off by the Board quarterly, it has to be submitted. So that if recommendations from inquiries are embedded into other requirements that are routinely signed off and MIS, the Maternity Incentive Scheme is one - I'm really sure that there is a perinatal mortality review process that we had to sign off and give assurance and Board assurance that we were on track with that. So that that's just something to note.

Professor Dame Jane Dacre: That would help, wouldn't it? Christine and then if I may, I think we need to move on. So Christine, last word.

Christine Braithwaite: Thank you. It was just about systematisation of inquiries and follow through of their recommendations. One of the things I think we included in our response to you was the fact that there isn't an inquiries office, if you like. There is no mechanism currently for following up on the outcomes of inquiries. And we've made some suggestions around that for the future – I appreciate you're not doing recommendations - but I do think that the lack of a mechanism for making sure that recommendations are systematically followed up on causes repeated inquiries and repeated recommendations of a very similar nature.

Professor Dame Jane Dacre: Yes. So certainly in reviewing the background literature, there is a theme of recommendations reappearing. Linda and then Tom.

Dame Linda Pollard: Very, very quickly. Because I think my main comment to the reviewer. Hello, Tom, long time since we've met.

Tom Kark KC: Indeed, hello.

Dame Linda Pollard: Good to see you again, hello. I completely take Tom's point about when you've done a review but I do have a lot to say, and I think it'll come in the next question, about implementation and how we embed it within organisations. So I completely concur, except I would suggest that the Messenger Review - for a specific reason, which I'll come on to in the next question, if that's alright, Jane - but you can do it, it takes perseverance, being quite annoying and dedicated to the role, quite frankly.

Professor Dame Jane Dacre: Yes. And I have to say - I haven't been involved at the same sort of level as you, but I do agree that you put all of this work into coming up with some stonkingly good recommendations and then they don't see the light of day. Tom?

Tom Kark KC: Very quickly on the point you just made. There is now somebody in the Cabinet Office who is being put in charge of all public inquiries, certainly in England, but she's just visited me in Northern Ireland. And I think one of the roles is going to be potentially the role you've just been speaking about, of following up recommendations. So I think something is being done about it.

Professor Dame Jane Dacre: Yes, I think it's becoming a bit obvious that something needs to be done, isn't it? OK. Thank you.

So if I could move on to our second recommendation in this section, which says: "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." This is from [the] Mid Staffs [inquiry]. And I think this is a way of discussing whether there should be set standards for managers. And in fact the other end of that discussion is about regulation, potentially, for managers. So that's my starter for 10. Who would like to come in and start on that one? Christine, then Tom. Then Andrew. Perfect.

Christine Braithwaite: Thank you. Yes. Just to say that the Professional Standards Authority previously, and its former guise in another name, was asked to develop the standards for that recommendation. And we produce the NHS Standards for Boards and Clinical Commissioning Groups. We were only asked to develop the standards, not to have a role in the implementation of them. And from our perspective, that's where the mismatch happened, in that standards were produced, and they went through a very consultative process to arrive at those. They included a pledge at the beginning to make it clear that patient safety was at the beginning of those. Subsequently however, the Fit and Proper Person Test, that might have been a way of enforcing them, didn't use the standards that we'd produced. So there was immediately a mismatch between the standards and the implementation of those. And our understanding is that the uptake of the standards generally was quite patchy. So some people were aware of them, but in general there seemed to be low awareness of it. And it wasn't very clear that, you know, "these are now the new standards, previous versions of any kind of standards are hereby revoked" as it were. So it was left with a rather patchy picture of implementation.

Professor Dame Jane Dacre: So again, a bit frustrating. So do you think that senior leaders and managers are aware that there's a code they should comply by? What's your view on that, Christine?

Christine Braithwaite: Our understanding is again that, no: in general, no they're not particularly aware. We have found very low awareness, even when we were talking to NHS England about the issue of standards, it wasn't generally known about. So we've had to continue to mention it and suggest to people that there was one, there was considerable work put into it. But it certainly hasn't been universally rolled out and adopted.

Professor Dame Jane Dacre: OK. Thank you. Andrew?

Andrew Smith: Thanks. I suppose, is it commonly known about and understood? I suspect not based on everything Christine said, I'd agree with that. I suppose just from our perspective of a regulator setting codes of ethics, standards of behaviour, et cetera: I mean, we have a common code for the 15 professions we regulate and actually if we look at the code that colleagues at the NMC and GMC all have, they're very similar. And from our point of view, not all, but a number of our registrants will end up in leadership positions. And we recently updated our standards. and they came into effect in September 2023, which had an increased focus on what it means to be in a leadership position as a healthcare professional. And I think the issue probably is, you will have a number of leaders in the NHS and other areas of healthcare, where they are a registrant of one of the regulators. But you'll also have people who aren't. And I suppose that's where the gaps are. And not understanding the work that Christine alluded to, and how do those things mesh together?

Professor Dame Jane Dacre: Thank you. Colin.

Professor Colin Melville: Well, first, just to agree with what Andrew just said, I mean the decision about whether or not there should be regulation of CMEs obviously is a matter for government. That needs to be their decision. But as Andrew rightly points out, there are few things we need to take into account. One of those is that increasingly we are seeing regulated healthcare professionals take on senior leadership roles, and of course they are already regulated. So we need to then think about what would be the implication for, say, a Chief Exec who is not from a regulating profession versus the Medical Director who is. Et cetera. So it's not as simple as it might seem, I guess is what I'm saying. And maybe I can just throw in a quick ad that the updated version of Good medical practice came into effect this morning.

Professor Dame Jane Dacre: Well done.

Professor Colin Melville: And we have brought some of the leadership content that was in supplementary guidance much more into the main body of the guidance. So we're saying that all doctors should have a standard, but we expect a higher standard of those in clinical leadership. So I think we've made that point. The other angle I suppose is - and our document is, as you know, called *Good* medical practice - is trying to describe the high standards in a positive way, supporting those who are doing a good job rather than a set of rules. You'll probably remember this Jane, that the original guidance from the GMC was called the Blue Book. And it was basically the list of naughty things you shouldn't do rather than the good things being covered.

Professor Dame Jane Dacre: Yes.

Professor Colin Melville: And I think that's a really interesting question about… the number of doctors who end up in FTP [fitness to practise] is relatively small. So you end up, if you're not careful, creating a rule book for a small number, when actually what we want to do is to encourage good practice amongst the majority. That's quite a sensitive area, I appreciate that, but that's something I think we would need to consider. So anyway, that's my free plug for GMP.

Professor Dame Jane Dacre: OK, so the polishing all the apples approach. Sam?

Sam Foster: Yes. I mean, I think health regulators are pretty aligned on the messaging that those codes, various codes put out. Ours certainly needs to be updated and that's in train, we've done joint work as well with the GMC around duty of candour, for example, and fed into the Times Health

Review and a range of other things. I guess one of the things that I always thought is that fitness to practice doesn't extend beyond the Board. And there's an opportunity there. And the updated Fit and proper persons framework, I think it's had quite a big impact and on Board colleagues particularly in that kind of leadership behaviour and cultural space. And I do think there's an opportunity, particularly in the big Trusts that we've worked in, where some of the divisional leads and sub-Board members have got huge spans of control and influence. So I think there's an opportunity there. And I know that NHS have done quite a lot around strengthening Board appraisals, leadership competence, et cetera. So there's a bit of a jigsaw coming together, but there's more to do, I think.

Professor Dame Jane Dacre: And I was going to say, do you think it's enough?

Sam Foster: Not yet. I mean, I think the new framework has got more teeth. I've certainly seen changes at Board level and Fit and proper persons. We've all seen the impact of Well-Led. But the new one, I think, has more teeth. But I think there's an opportunity to extend it wider than Board members. And as we've all said, clinicians in senior leadership positions - there's more anchor points that we can use around expectation. But there's certainly a gap for the non-clinical.

Professor Dame Jane Dacre: Linda?

Dame Linda Pollard: Yes, this this is the piece that I thought I'd probably be able to help the most in. And it goes back to the Messenger Review, our Messenger Review. What happened after the review - it goes back to the last comment. It was owned by the then Secretary of State, which was Matt Hancock. Started by him, implemented by him. And within months we all know what happened there. The good news there was that we were in the middle of the review when Sajid Javid took over, who again owned the review and agreed with it. And four Secretaries of State later, we've kept passing this on. But the real key point that I really want to make is, where it fell down – and I think this is what's happened with Tom's comments before and others about reviews – the agreement was at the point when Sajid Javid had it, was that we would move to Implementation Board. And the Implementation Board was going to be made up with both the Department and NHSE. And it would be holding whoever to account for delivery. And on this particular question, it was Recommendation 3, "Consistent management standards delivered through apprenticeship training", part of which [was] "a single set of unified core leadership management standards for managers." Then and now, I was pretty determined - and Tom's referred to it - you've got to be pretty determined to keep it live. You keep getting referred to in goodness knows how many conversations, how many debates. But implementation is not a word that is easily digested. And we can talk a lot about recommendations. And we talked to you, Tom, well we talked to everybody, Stuart Rose et al. So coming back to implementation, what's happened now is that it moved from implementation to Advisory Group that sits within NHSE. It's a four-year plan. The first year was last year. I won't bore you with all the details… in fact, I'll show you [holds up document] that's the workforce plan: masses of detail. But when we come to implementation, that's another question, it's my frustration as well, because it's not an implementation group, it's an advisory group. So the pace by which we've been able to go through this whole period has been cripplingly slow. We have got to the point where Year One was all the detailed work that was being done and progressing to what is now a three-year plan, my comment would be that, Year 2 and 3 - there is so much to deliver. And this would be delivered ostensibly by NHSE with other partners that would have to be commissioned to do it. And I think my real concern is that there isn't either the capacity or the resource within NHSE - they've just had, obviously, a massive reorganisation themselves - to deliver on this. But definitely within that, on Recommendation 3, it quite clearly states – and I just went back to make sure it was absolutely on Year 2's plan, and it is in there for Year 2. But implementation I think is the keyword to all of this. There's an awful lot of rhetoric. There's a lot of goodwill. The deliverables then… It's very

complicated, a lot of what's in there. It needs simplifying, it needs, probably, some serious leadership and ownership by which to then start implementing. Let's stop talking and start doing, basically.

Professor Dame Jane Dacre: Thank you. That's quite a strong theme that's coming out, isn't it. Tom?

Tom Kark KC: Yes. So I just want to say I think to a large extent it seems to come down to the political appetite to follow a large recommendation. I'm very conscious that the first four recommendations that I made in relation to setting up a set of core competencies; having a proper database; having mandatory references so you can't have vanilla references; following a compromise agreement; extending the Fit and Proper Person test to ALBs. All of that has actually not been done by legislation, but has been done by guidance. And I'm really pleased to hear from Sam that the new framework is regarded as having more teeth than the old. And I'm going to take a little bit of credit I hope because I think at least some of that came out of my recommendations. But the big one, Recommendation 5 (which was – and I understand that this would be very challenging - to set up a limited regulator, so that you can actually disqualify health directors who have been found guilty of serious misconduct) obviously hasn't happened, although I've had both the last Secretaries of State on the phone, telling me after Letby was convicted, how interested they are in that. So whether that's going to happen or not…. But I think that comes back to the comment Colin made about the mismatch between the regulated and the unregulated on a Board. And certainly the medical directors that I spoke to took the view, "well, this is just not fair. I've got a regulator, the nursing director, if they're on the Board, have a regulator. But none of the other people - and some of the other people have much more power, including very often the chief executive, who may well not, of course, be medical - they're unregulated." And I was asked to comment about Letby, and obviously I chose not to comment about that because I didn't know enough about it. But certainly from what was reported in the press, there were a number of consultants who were complaining or raising serious concerns and effectively being closed down. But I do wonder if they had had another avenue of complaint - other than within the Trust itself - whether actually they would have felt a little bit more empowered. That's more about the recommendation other than whether it will be implemented. But it needs a lot of political will to set up a regulator, and I understand that.

Professor Dame Jane Dacre: Yes. So, it looks as if the code of conduct is good, but whether that goes far enough and whether stronger clout with regulations is a good thing, but it would be complicated.

Tom Kark KC: Yes, indeed. And also one has to remember all of this is just framed as guidance. I take it from what Sam has been saying, that the guidance is actually being taken seriously, which is very good to hear. But for anything else, legislation would be needed.

Professor Dame Jane Dacre: Yes, which is non-trivial.

Tom Kark KC: Indeed, I totally appreciate that.

Professor Dame Jane Dacre: Can I now move on to our second main area, which is training of staff in health and social care and the recommendation that we have picked out here 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." This is from the Health and Social Care Review and Inclusive Future Report from 2022. So, in people's experience, do staff across health and social care receive effective training on collaborative leadership and organisational values? Before anybody puts their hand up, I know, Colin, the GMC have been looking at specific induction programmes. Do you mind getting us started on this? How effective has that been?

Professor Colin Melville: Yes. Don't get me started. So we've done a number of things. So we set up a free access programme called Welcome to UK Practice, which was particularly aimed at international graduates - I was going to say “for obvious reasons”, but you know, culturally, coming into a country and then working in a different healthcare system. And in the past ten years, over 35,000 doctors have attended that. Now the feedback we've had from it has been largely positive, but I fully accept there is a difference between people's perception of its value on the day and later. We've been trying to do some work on that, but I don't have any specific information. But what we have been doing is offering it through different media: so we do it online or we do it face to face. So that gives more than one option. The other thing we have of course included - I'm sorry to get back to good medical practice but in fact it was our kind of media line about creating respectful, fair and compassionate workplace. And that's why we think induction is so important.

So let me pause on that and I'll let other people come in. There are some probably other related points I could make, but certainly we believe that induction is important and we're keen to see that picked up by NHS organisations more formally.

Professor Dame Jane Dacre: Thank you. Linda?

Dame Linda Pollard: I think this is particularly important and it was something that was heavily emphasised in in our review, but equally has been picked up by this work programme that NHSE is in the thick of formulating, which will be frameworks and it won't be just guidance. However, I've just read back, it says “deliver a framework for a standard national entry-level induction for all who join the NHS and social care”. Now induction has started in a mild way through NHSE. They would say that they started this last year, but that was I think… they've done two, from memory, large induction events into the NHS in London. However, it did not include Social Care in the end, because it is a separate department within government. And it comes back to the point that Tom made earlier: a lot of this is political ownership. Although, when we were doing the review we found getting social care to the table was relatively easy. The most difficult part was primary care for the obvious reasons, they're all separate businesses. But certainly social care were regularly witnessing to us. But definitely induction has fallen away as far as social care is concerned. I've overstepped that in West Yorkshire and Leeds, here. In fact, literally, I'm in a very strange room that's unbelievably noisy and hot now, because we've just been doing exactly that across our Leeds place. And we're all together, along with social care, we've got the third sector, the charity sector, mental health. We're all in it together. And I've just stepped out to come and do this [meeting] literally. So with it, there are good pockets of this going on. Because it's incredibly important at times of real fiscal problems as well, that you share the problems and you learn together. Well, I call it learn together, work together. But unfortunately nationally it's fallen apart a little bit.

Professor Dame Jane Dacre: So it's patchy. Just to summarise, or if you could summarise, the groups that you think where it's been done well and where it hasn't: you say that social care has been left out and primary care have left themselves out. Is that….?

Dame Linda Pollard: More or less, in the whole programme of things. We’ve got a group called the Management and Leadership Advisory Group, MALAG for short. And they have been to the table but, unfortunately, when it came to looking at the induction piece, I didn't know this until quite late actually, that it was only health people that actually went to the induction events, not social care. And I found that particularly disappointing if I was honest. But equally, primary care have a role here as well.

Professor Dame Jane Dacre: We often find, in the work of the Expert Panel, that social care somehow keeps being an afterthought, that does seem to be a theme. Andrew? And then Sam.

Andrew Smith: Thanks. I think there's quite a lot in this area of the discussion. So we know that good induction and the early experience of people is an important part of an individual practitioner’s ability to practice safely. You know that's going help. But also if we look at the system overall, we know if that early experience isn't good, they're more likely to leave. And therefore the workforce crisis that we have, if we don't retain the people we've got, it's like filling a leaky bucket in terms of trying to either train more people in the UK or recruit people internationally. So I think from a safety point of view, there's two aspects to it: the system as a whole and retention of the workforce, but then also supporting the individual to provide the best possible care to patients on individual basis. I suppose a bit like Colin at the GMC, we've been doing Welcome to the UK workforce events as well, for those people who joined our register from outside the UK, who trained outside of one of our programmes. And I think people like them because there’s that cultural challenge of coming to work in the NHS in particular. Regardless of the different parts of the health system. It's a big deal, moving from another country and adapting to the ways of working in the UK, like it would be going to any other country. Anecdotally, from when I speak to employers, professional bodies, and unions, I've heard some really great examples of where there's individual employers really helping those people they recruit from outside the UK, making sure that their transition over to the workforce over here is well managed and they're supported. But I also hear examples about where people are basically brought in and they're treated almost the same as if they're qualified in the UK, where obviously you would have done your training in the UK, you would have grown up in this health system. So, I definitely think that there's variety out there and I think that's why we developed the programme, a little bit similar to the GMC. And I suppose that that's a bit about international. I suppose the other side is the UK workforce and supporting them as well. So yes, they may have trained in our health system, but it's a big difference going from being a student and then gaining a professional qualification and entering the workforce and that sense of autonomy perhaps, and responsibility and accountability you have as a registered professional. We've done quite a lot of work recently on what we call preceptorship, which is supporting people in that transition from being a student to registered professional. But again, we know has a big impact on how people feel in terms of their confidence in their abilities. And we haven't quite published this yet, I think we’re due to publish it in in March. We commissioned a bit of work with the university to look at how newly qualified students, who trained in the UK, how confident they felt. And the findings at the moment suggest that they feel confident in their clinical skills, which is good, but they feel less confident in applying those skills in a stressed and pressurised environment. And if you think about our health system at the moment, it is under pressure. And that's quite interesting. You know, we've got students coming through going into practice and that's how they feel, I suppose, after the first year or so of practice. So there's quite a lot in there. And I think that that's all about, from my point of view, that's talking about our experience of people who are regulators. But obviously the workforce and induction programmes will cover many, many people that work in the health service who aren't regulated, so they'll have a different experience on top of that as well. Sorry, I'll stop there.

Professor Dame Jane Dacre: Yes. Sorry, just to ask you a supplementary question: do you think that does relate to promoting and protecting patient safety, these induction programmes? And then a second supplementary question: is it adequately resourced?

Andrew Smith: In terms of in an employer context, is it adequately resourced? I’m probably not close enough to comment on that. What I have heard from speaking to different employers is that some invest in it very heavily and others don't. So I think there's definitely a mixed economy out

there. I’m probably not close enough to it to pass judgment on whether it's adequately resourced in general.

Professor Dame Jane Dacre: OK. And relation to patient safety?

Andrew Smith: Well, I think I said at the start, I think it’s on two levels, yes. So if we don't support people they leave, and if you leave, then you've got an under-resourced workforce that will have an impact on patient safety. But then also that ability to enable and support people to do their job effectively, as Colin said, has to be influenced by good induction and making people feel confident in applying their skills in the right way.

Professor Dame Jane Dacre: Excellent. Thank you very much. Sam?

Sam Foster: Yes, to add on top of that, there's no doubt, is there, that the evidence base is that onboarding improves retention. And I think to hear Linda's example of leading from the top is incredible. Because the variation is: ICS-led, senior-led “this is really important”, down to “complete 16 modules of e-learning”, you know, “box ticked”. So I think we got some significant variance there. Notwithstanding that, for clinicians alone to do their own statutory and mandatory training, you're looking at sometimes 20 to 25 days for you mandatory stuff in addition to what you might need to do for anything that an organisation or an ICS might see as important. So there are some definite rate-limiting steps. I think we tend to do it profession-specific, when there's a real opportunity to come together, in the teams that we work within, to consider the patient safety. Social care is absolutely not invested in. The long-term workforce plan doesn't make good reference to how this needs to be delivered, which makes it difficult to anchor in. And people just start scrabbling around really. Now we've continued to do Welcome to the UK as well. In all honesty it’s probably an employer responsibility to welcome their international-educated colleagues, but there's a huge gap there. And you've heard from all three of us that we are plugging that gap in our influencing and supporting role. We're just gaining more and more insight and evidence of really difficult experiences of colleagues who have joined us from overseas, that we need to act on.

Professor Dame Jane Dacre: Linda and then Colin.

Dame Linda Pollard: I'm just concurring, I'm nodding my head away here, Sam, vigorously. But it isn't just overseas colleagues is it? Because induction for me - which is the disappointing part of why we haven't, you know, implemented more, to create a proper framework that people have to adhere to. And it shouldn't be at the behest of just well-organised Trusts to actually implement their own. Because what you've got, in terms of induction, particularly for people coming into the NHS, whether this is actually clinicians or it’s management or if they’re coming in from other sectors, you need that national induction
into ‘what is the NHS, social care, and the whole structure of how health and social care works’. But then you've got what I will call the more local induction into the whole of the organisation’s values, its cultures, which obviously tips into patient safety. And the whole ‘what you stand for’ as an organisation sitting within the health sector. And, our induction here at Leeds is a whole day. And the subsections of that. And what's really fascinating, I'm currently reviewing the e-learning modules - yes, OK, we know there's lots of e-learning modules in lots of sectors, and I've worked in a lot of sectors - and I've just been asked to review them, which is my joy, I start tomorrow, seven and a half hours of modules which are ostensibly for non-execs, which have come out of the Leadership Academy, they’ve been used for years, so presumably I've got this purgatory because they're probably well out of date. But it's not the same. You need hands-on. You need the CEO. You need the Medical Director. You need staff, and, induction, you can have new consultants sitting with the cleaner. It’s absolutely, totally irrelevant. It's owning the culture of the organisation.

And that's disappointing for me. That is one of the first big disappointments. There are many more, by the way. But that's where the recommendations haven't got the grip that they should have. Because this isn't a choice thing. This is just totally out of order, quite frankly.

Professor Dame Jane Dacre: Yes. So, the relegation of things to a learning module that people pretend they're doing whilst they're, I don't know, doing something else is… it is easily done and difficult to change, isn't it?

Colin, and then if I may, we'll move on to our third and final big area. Colin?

Professor Colin Melville: Yes, sure. I'm sure we could have done an e-learning for health version of this meeting, but as Linda says, that doesn't solve anything.

Professor Dame Jane Dacre: Well it wouldn't have been such fun.

Professor Colin Melville: No, and that's my point. I mean, two things struck me: one was that in that statement, it kind of slightly separates the organisational values from the national-entry level induction. I just wonder whether the framing of the recommendation is partly defeating what we need to achieve. That's kind of a side comment.

Professor Dame Jane Dacre: So, well, as a general comment, actually that's something that we come across, where there are difficulties in the way you might expect a recommendation to be implemented because of the way it's written.

Professor Colin Melville: Yes. And that's always a challenge, isn't it? I was just sort of thinking about… so for example, there is a UK-wide foundation doctor induction. Time allocation. I won't say there's a programme because I'm not sure that there is an agreement about what should be in it. But I do wonder whether, again, picking up on Linda's point, is - we do an awful lot about the stuff and the process, not about the 'who we are and what our values are'. I'm sorry to do this again to you, but we've introduced culture as being about values and behaviours as a central plank of good medical practice, under the section of 'colleagues'. Because actually that, to me, is one of the things that in terms of health, and indeed social care, if we can start to build the right culture some of the other things will follow. What we tend to do is to pick at the end points and, you know, "you've got to do this and do that and do the other", rather than the culture of an organisation. Which seems to me to be really a key component to unpick this. And I've spoken at many meetings on the question of culture. We use that word, we use it so easily. And I usually ask the audience, "well, what do you mean by culture?" And I've seen it used in a few recent reviews, and it's not clear what is meant by it. So, for me that's really important. So, settling that, actually, part of induction is about values and behaviours. What does this organisation stand for? What are we promoting? Back to my point about, let's pick up the good points and empowering people to speak up where values and behaviours are not being followed.

Professor Dame Jane Dacre: So, in answer to the question, I think the answer is a no, that it's patchy and it doesn't necessarily cover the right things. Kath, you've got your hand up.

Professor Katherine Woolf: I was just going to say that if anyone wants to add anything by email afterwards and then you're very welcome to. I'm just aware that we're running short of time.

Professor Dame Jane Dacre: I'm going cut short and we're going to move on. And this has been a very helpful conversation that I'm sort of truncating and summarising in order to get through the time. My apologies for that. So now, if we may, we want to move on to our third area, which is the

culture of safety and whistleblowing. Now we could talk about this for the whole of the rest of - well, we are going talk about it for the whole of the rest of the afternoon. But we won't have enough time to do it justice. So the comment about if there are other things, or other thoughts that you have, please do feel free to get back in touch with us.
So the recommendation that we've suggested to look into here is about the 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. Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis. System regulators should regard departure from good practice as identified in this report…” (this is the Freedom to Speak Up Review) “…as relevant to whether an organization is safe and well led.” So how effectively do NHS organisations ensure that staff feel safe to raise concerns? Colin and then Bernie, can I put you on standby from a pathology perspective? Because I think you often see things behind the scenes that maybe are not overt to those of us who are working absolutely in the front line. So Colin, freedom to speak up.

Professor Colin Melville: I'm just going slightly reiterate what I just said. Because this, we're now eight years after that report was written, and I think the problem is in the wording ‘culture of safety’. If you talk about the ‘values and behaviors that promote safety’, that's easy to understand. I don't know what a ‘culture of safety’ is. And I think that's part of the difficulty. And so therefore, I'm not sure if you were to go and ask staff, “do you think we've got a culture of safety?”, they wouldn't know how to describe it all. But if you said “have we got behaviours and values that promote [safety]?” that would help. That’s a point of detail. We, of course – and this isn’t, well it is in Good medical practice, but I wasn’t going to refer to that. We did update our guidance on *Raising and acting on concerns about patient safety*, so it is a key part of being a doctor that you should be able to raise concerns without fear. And that was updated in November 2021. So I think we've sought to do work on that. And we've also been doing some additional work with doctors, so nearly 16,000 doctors have been involved in the past 12 months in programmes that we've delivered within Trusts about promoting safety and about culture, values and behaviours. I'll stop there because we're short of time.

Professor Dame Jane Dacre: Thank you. Sam.

Sam Foster: I'll keep it brief as well as we could go on all day, couldn't we? I mean, I think it was worrying the latest national report from the National Guardian's Office, which showed a deterioration in how it feels to be around the NHS. I think there are big opportunities in some of the staff survey questions that we should pull out. You know, we tend to, at Boards, do a kind of overall, kind of “average here, there” and “we've gone up a few and down up here”. And I think there are some pertinent questions about how it feels to raise a concern that could be maximised on. I'm still fairly shocked around the variation in use of the Just Culture guidance. I think it's an incredible tool. We don't use it in screening in the NMC. We will be, but we don't. I can't believe that. I do loads of talks to lots of nurses and half of them have never heard of Just Culture. I just can't get my head around it, but anyway, I think there's an opportunity there. I'll just use one phrase that I think is really important. When I worked in Birmingham and Sir Ian Kennedy came and did the review post-Mr Patterson's suspension, at that point he hadn't gone to court. But he used this phrase, ‘the cloak of HR mystery’, and that's always stayed with me, because that sometimes covers everything. And people think, well, “everybody kind of knows I'm not going to….”. You know, there's something about the management of people and patient safety and that ‘cloak of HR mystery’ that just stops people talking. And sometimes things will continue, but people are frightened of raising concerns because they believe that the right people know. And that's always stayed with me.

Professor Dame Jane Dacre: Interesting. A great phrase, actually. Andrew?

Andrew Smith: Yeah, there's something about before you get to the whistleblowing stage, where something's got so bad that someone's effectively blowing the whistle. It is creating that environment where concerns are discussed openly, early and listened to. And so a bit like Colin, I'll keep the updated standards top trumps going with him. But in our update, we've done a similar thing about promoting duty of candour to encourage all students to raise concerns really early in the appropriate way. And I think that's the onus on the individual. And then you get to the bit about well, what does the person you're reporting that to do with that information? And I think in the numerous different enquiries that are mentioned in the pre-reading for this, that is often where falls down. It's not necessarily the individuals flagging a concern, it's how was that concern acted on? And we had a long conversation at the start of this about managers and regulation of managers, so I won't take us back down that route. I suppose the final bit that strikes me in this area, is when we do work well together as regulators - and by that I mean with the system regulator as well, in England with CQC - it's that ability to piece together bits of information earlier. I mentioned at the start of the session around the Emerging Concerns Protocols which have been set up over recent years. And I think that that is a mechanism we've used as an organisation to both share information with CQC and also we've had information shared with us. And it is helpful, but I just think we're just not doing it enough. I can't believe we're getting a full picture of what's really going on out there. I think Colin and Sam talked a bit about sharing data and the work that their two organisations have done in maternity. I think there's a gap there for the whole system, not individual organisations, how you piece that data together to work out where things are going wrong, before it gets to a whistleblower stage.

Professor Dame Jane Dacre: Thank you. Tom?

Tom Kark KC: Just very quickly to say, first, I completely agree, as I'm sure we all do, that the word culture can be completely meaningless. And I'm guilty of it, because I know I used it in my report. And we also all know that policies and documentation don't make a culture, it's people. And it's having, it seems to me and I spoke about this, having senior people visible. Because it's all very well saying “my door is open”; if nobody ever walks through it, it's pointless. I don't think we all – in a sense we're all sort of fairly senior in our own fields - but I'm doing a public inquiry at the moment, and the sheer fear involved, actually, by junior members of staff in raising issues when they feel that there's a real danger they won't be listened to. I know these will be absolutely obvious points that you know extremely well. I do wonder how well the Freedom to Speak up Guardian system has actually worked. I know people who are very close to me, who are in the NHS, when I've asked them, “who would you go to? Your Freedom to Speak Up Guardian?” They've got no idea even of the system. I'm not going to name anybody, OK?

Professor Dame Jane Dacre: Thank you. No, well I think that's right. It's very difficult to get these things rolled out and - I hate to use that culture word - but to make them business as usual for people who are working on what you might call the frontline.
Linda, I was going to ask you how it's worked at Leeds. And then Bernie, I'm going to ask you how it works in pathology. So, Linda?

Dame Linda Pollard: Well, I would say brilliantly. And absolutely Tom, I'll give you 10 out of 10 for this one. The Freedom to Speak Up Guardian - funnily I was at our board meeting last week and he comes three times a year to report in, I see him on the Exec corridor with huge degrees of regularity. But it is that getting out, it's the culture. I hate to say it. It's the culture and the leadership, isn't it? And culture is leadership. It's people. We're a people business and we forget that at our peril. Whether it's the people we serve or whether it's our staff.

But I would say, it's one person, the Guardian. And I know from last week's meeting that he has recruited (our guy) 60 'disciples', as I called them in our meeting, right across the piste. And if you go out of my office and I go stand in the Costa queue, or, you know, I don't have my lanyard on, and I'm walking about, I hear all sorts. And I'm quite known for butting in, and that's where you get your information. So 60 people in our organisation, I think that's a joy quite frankly. And I don't care if they all come back with something, because that's learning for us. And is there a pattern? And then people get more and more confident that they're not going get the head chopped off by saying they saw something, or somebody's behaviour was not to our values, or whatever. So I'm delighted by our Freedom to Speak Up. Could I say, hands up, because obviously, the national work I do, I see a lot. It is within the framework – oh dear, I got back to that – of what NHSE are trying to do. But it's not there yet. And do I hold out hope currently that it's going to be implemented? No, I don't.

Professor Dame Jane Dacre: OK. And why not?

Dame Linda Pollard: I just think that we - and I'm sure Sam's going to, hopefully, agree with me here - there's such a variance in the quality of the leadership we've got. And I'm talking Board and senior leaders and therefore managers in the system. And they don't have to be big organisations that aren't, you know. Yes, my bar's high. I get that. Not everybody's going to get to that. But the thing is, it's disappointing when you hear and see perhaps leaders not behaving in a manner that is appropriate to create a good working environment for staff, and better patient care. But unfortunately it isn't that yet. Again, I'm sorry to say, but this was part of what is well within the Messenger Review, it's all there, detailed as to what we should be doing, how to encourage that. Professionalising the management part of it in a more respected way, that is totally recognised in other sectors, but not in ours. It's not magic dust, you have to work at this. And good managers don't always make good leaders. Let's get that clear. But you can identify them with your organization. And then you've got to put big succession planning in. In the times that we're living in that is difficult to encourage people to do what we have historically done. There's a discussion going on at the moment about that. I think it's just that, we don't learn from the best always, we learn from the worst, and mistakes happen and then we all react into, whose fault it is, as against having a proper framework to start with, an understanding of, you don't become a leader in an organisation to develop a good culture unless you've done A, B, C, D, E. And that's professionalising. And it's not there yet, unfortunately.

Professor Dame Jane Dacre: Thank you. Bernie, I've been threatening to bring you in, from the perspective of pathologists who are everywhere within healthcare.

Dr Bernie Croal: Yes, I guess we're quite fortunate, or maybe unfortunate, in that we've seventeen quite different disciplines coming under the pathology umbrella. We get an insight into clinical services and whether they're doing well or doing badly quite quickly, when we see the reflection on the work that we get asked to do and the clinical work that we become involved in. Pathology, like everywhere, is struggling in some areas more than others, with staffing issues and that will continue to be a theme. And that's going to reflect the amount of work we're able to do obviously, and that puts pressure on the system and on individuals. And we're beginning to see the cracks in that. But it's the clinical side that, for pathologists like myself, where I'm mostly clinical based - so I do ward rounds, I have patient clinics, all that kind of stuff - and the thing I've noticed, both certainly in the wards, but also in our patients especially, is that with the deterioration in NHS care over the last few years and the deterioration in patient safety as a result of that, it would seem that the bar has changed quite radically on where staff are now willing, or see it reasonable, to whistle-blow. Things that were completely unacceptable five years ago even are now "well that's just normal". Going onto a ward round and seeing patients on trolleys, not just in A&E [accident and emergency], but in every single ward. And in treatment rooms, all that kind of stuff, not getting the care they have

because they're short staffed. These are big, big patient safety issues, and staff are no longer blowing the whistle on that because it's become normalised. And that is a big, big concern to me. And similarly, when we look at pathology samples, we know absolutely that there's been a huge change in cancer, in terms of patient samples. While our pathology work has not increased in terms of number of samples, we've seen big changes in the grade of sample, the complexity of the sample, the stage of the malignancy that's being presented. And that's a reflection of absolute, catastrophic impact on patient flow. So in terms of the whistleblowing side, I think overall – I can only speak from the areas that I've been involved in, and I've been Clinical Director worked as Medical Director on call and things – and I think the whole approach to whistleblowing, certainly in Scotland where I work, with duties of candour coming into play, it is much more open and much more easier to whistle blow but it's just that staff are not doing it as much, because all the bad stuff is now being accepted as being "well, that's just normal, no point in whistleblowing".

Professor Dame Jane Dacre: Gosh, that's a bit scary. Thank you very much. So I've got Colin and then Christine.

Professor Colin Melville: Yes, two quick points, probably in part relating to what Bernie has said and what Linda has said. As someone who gets sight of a wide range of organisations across the UK and the whole sector, it is sadly true: there are some outstanding organisations from our perspective in terms of its leadership and the culture it creates, but there are a lot of others as well. Two caveats to that which is, I think we need to dispel the myth that seniority and length of service are not good criteria for selecting leaders. And I think that, as someone who comes from both an NHS and an academic background, that applies. The fact that the professor is the most longest serving person in the department does not make them the best leader of that department. And the same is true during the NHS. So I think that's something we need to figure out how to change. And I think a lot of cultivation and much more mentoring-type approach to leadership is probably going be far more effective than another proliferation of MBA-type courses. Courses don't make good leaders. It's about how you live and the values that you hold. So just wanted to make those two quick points. And of course, if you do that, then the whole point I think Andrew made about people feeling able to speak up without needing to resort to whistleblowing, that creates exactly the environment we want. Whistleblowing to me is something we don't want. We shouldn't need to have to use it. We should create a different environment. Anyway. I'll get off my pedestal and just wave from Wetherby across to Leeds because that's where I live.

Professor Dame Jane Dacre: So it's polishing all the apples again. I was going bring Christine in and then we've got to talk about GP.

Christine Braithwaite: Thank you. So we've been really interested in the whole issue of whether or not people will speak up, the duty of candour. We advised on duty of candour of a number of years ago. And in answer to the question, "does it look as if NHS organisations are ensuring that people feel safe to speak up?" I think the answer has to be no. It's quite clear from a number of inquiries and investigations and reports, we repeatedly see evidence that people aren't speaking up. Paterson inquiry, the consultant that reported in relation to Paterson and blew the whistle there, he was clear that several colleagues knew that there was a problem but hadn't said anything. I think time and time again we see examples where it's not happening. I also think there has been an extraordinary amount of good work done to try and change it. And so the question always in my mind is, so why, despite all of this, despite all of the effort, we have a legal duty, we have a professional duty, joint statements by all of the regulators, Freedom to Speak Up Guardians and so on. Why is it still difficult for people to do it? And the conclusion I draw is that because we haven't focused enough on what the barriers are. Where we tend to rest is with exhortations to people to give good leadership, to model the values and behaviours without really unpicking what the barriers there are. And one of

the things I think is particularly key in health, and social care no doubt too, are conflicting loyalties. So people who work in healthcare have a number of loyalties. They've got one to their patients. They've got one to their profession, particularly if they are a member of a professional body and a member of a regulated one. They've got loyalty to their employer. And then they've got their own self interests. And those things frequently come into conflict with one another. And then it's not clear what the hierarchy is. So does patient safety, does your loyalty to your patient trump your professional loyalty or not? And I think what we often see is that professional loyalty will trump patient loyalty. So if you're going to crack that nut, you need a really good understanding of the kind of psychological mechanisms that are at work and how one can try to shift that so that people are always clear: “my first priority, my first loyalty is to my patient. My second priority, my second loyalty is to X, Y & Z”. So people understand how those fit. And we really haven't done work in that. There will be motivations for the managers who aren't providing that leadership. For the leaders that aren't providing that leadership. And I don't think we'll ever get further forward unless we really acknowledge that there are those barriers, they are real and we need some really good organisational and personal psychology to help understand how to change that.

Professor Dame Jane Dacre: Thank you, that was absolutely fantastic. Now listen, we've got about one minute to talk about primary care. Now, I don't feel that bad about it, because none of us are in primary care. But the question is, how does all of this stuff that we've been talking about ladder across to primary care? So very short last answers about whether or not the discussions that we've been having about a culture of safety and whistleblowing are adequately reflected in primary care. Now in the middle of our conversations around this, we're probably going to be cut off and beamed back into the main room. It won't be because of anything you said, it would be because of my poor time management. So, comments about primary care. Colin?

Professor Colin Melville: I think Christine's point is the key one. This loyalty, I was really struck by that. I've written it all down. That your loyalty in primary care may be even more self-interested because it's a business than putting the patient at the top. Guess what? GMP says “make patients your first concern”.

Professor Dame Jane Dacre: No, not that again.

Professor Colin Melville: Sorry, end of.

Professor Dame Jane Dacre: We just need to do it. We just need to blooming do it. Other comments in relation to this extrapolation across the primary care before we get turned into a pumpkin?

Christine Braithwaite: Just to say I second the idea that business is an additional conflict.

Professor Dame Jane Dacre: Yes. Sam?

Sam Foster: I think it goes back to that variation, doesn't it? There are some excellent federations and groupings. But equally there's some really poor governance and people that don't even report patient safety incidents, let alone learn and discuss them. And right through to some excellent examples of learning and good safety environments, culture, good leadership.

Professor Dame Jane Dacre: Thank you. Any other comments in relation to people's understanding of what happens in primary care? And that does seem to be a general theme about how messy the whole system is, isn't it?

Professor Stephen Peckham: Yes, I was going make that comment. I mean, I haven't said much, but

there does seem to be a fragmentation in the accountability structure. So you've got multiple regulators, you've got fragmented delivery systems. So trying to do things, slam bam across the system is clearly not going to work. So the idea that everybody has a standard induction, well, who regulates? Where's the accountability? Who is the Board answerable for if you don't do the 'fitness to practise' type stuff? And I think some thought needs to be going into that more general governance. I always remember the old Regional Health Authorities would have Boards up in front of them, you know, "what are you doing?". We don't have that sort of similar… In fact ICBs were originally not going to have any regulatory authority across their local system, in the original view. Somebody has to hold the can. And as I said, you can't do it nationally. And the different regulators… I think in general practice there's an issue that, yes, GPs have particular mandates, but the multiple accountabilities for a general practice are enormous. So I do think we need to be maybe thinking a little bit about the governance of some of this. And I think, I can't remember who said, having somewhere that people can go to - because it's not just a junior staff, many senior staff don't raise issues. I mean, that's been true in many of the commissions. Sorry, Christine.

Christine Braithwaite: All I was going to say was yes, I mean, we write about this in Safer Care For All. But essentially somebody needs to have the role of making sure that the safety system operates as a safety system. But we've got a lot of working parts, but no one who makes sure that the aeroplane will actually fly when those parts come together. No one spotting the gaps. That's what we're missing.

Professor Dame Jane Dacre: Yes, it's very interesting. How are we doing? It looks to me like we're about to be called back 2 minutes.

Professor Katherine Woolf: Two minutes.

Tom Kark KC: Just very quickly, I remember talking about this at a patient safety conference ages ago and I don't know how many boards have a NED, a non-exec director, on them, specifically with the focus on patient safety because I don't think they all do.

Dame Linda Pollard: So it theoretically would come through your Quality Committee, where your chair of that Quality Committee is a NED absolutely, categorically.

Tom Kark KC: Would be on the Board, yes. I just don't think it always happens. And I do think having somebody on the Board with that specific focus is crucial. But you all know the system a lot better.

Professor Dame Jane Dacre: So does anybody know how that might work in primary care?

Professor Stephen Peckham: There is no NED. And I can speak as an ex-NED, that actually sometimes what you as a non-executive say on a Board tends to be overdriven sometimes by the more professional executives.

Dame Linda Pollard: Not on my Board, Steve.

Professor Stephen Peckham: I'm sure that's very true, Linda. But having been on a couple of Boards, it clearly happens.

Professor Dame Jane Dacre: Right. OK. Well, I think any second now, are we all going to disappear?

Professor Katherine Woolf: Yes, absolutely. Thanks so much. Sorry for haranguing you a bit about the time.

Professor Dame Jane Dacre: And thank you for a fantastic conversation, it's been an absolute pleasure to hear from everybody. Amazing insights. And we will all disappear.

End of transcript

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