THIRWALL INQUIRY

EXPERT REPORT

PART TWO

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1. Reorganisations of the structure, governance and management

Please comment on how, if at all, reorganisations of the structure, governance and management of the health service and organisations formed within it, such as NHS England, the Health Service Safety Investigation Branch (HSSIB), Integrated Care Boards etc., impacts on the effective implementation of recommendations made by inquiries to improve the health service?

1.1 As I observed in the introduction to my consideration of Question 1 above the NHS is less of a system than a series of entities, similar to planets which orbit round each other without necessarily connecting or communicating, at least not consistently. Throughout the time in which I have observed the NHS it has been delivered through a large number of organisations or entities. This is purportedly overseen by a large number of regulatory and oversight bodies, so large in number, in fact, that there is often disagreement on how many there actually are. A constant complaint from leaders of front-line organisations is that an inordinate amount of time is spent by them and their staffs in reporting to, and addressing regulatory demands of, these bodies, with sometimes overlapping jurisdictions, and perhaps more in the past than now, often seeking the same information but in different forms and at different times. I observe that a constant of NHS culture is that the very dedicated people who work in and lead it, will often agree on values, the outline of strategic thinking and actions required to bring about improvement, and so on, but find it impossible within their own area to integrate and develop these in their own context.

1.2 Before turning to the effects of structural changes it may be helpful to look at the experience of those at the centre of such change, the executive leadership of frontline organisations. One obstacle in the way of successful leadership has been the constant churn of people holding leadership positions, particularly at the level of chief executive of an NHSFT. A King's Fund survey in 2014[1] found that a third of executive level board positions were vacant in acute trusts. The same report highlighted research showing the perhaps obvious conclusion that a high turnover of Chief Executives is associated with poor performance. While it could be argued that poor performance may be a reason for changing the leadership, this can become a self-fulfilling prophesy. The report cited literature and staff survey responses suggesting that high turnover has a "*chilling*" effect on leaders' willingness to launch bold improvement initiatives. The report referred to the way in which things going wrong affect careers and confidence, quoting one national stakeholder as saying:

> *People who are confident in themselves accept there will always be a Mid Staff – but the criticisms are more personal – people want someone to blame and have your head on a pole, and the government encourages this.*

[1] Janjua, *leadership vacancies in the NHS, What can be done about them?* December 2014 King's Fund https://assets.kingsfund.org.uk/f/256914/x/1e34b956ac/leadership_vacancies_nhs_2014.pdf [downloaded 11 March 2024]

1.3 A report of a 2017[2] survey found that 54% of executive directors have been appointed in the previous 3 years and that the average tenure was only 2 years and that higher vacancy rates were associated with trusts rated "*Inadequate*". In 2019 NHS England published a long term plan, part of which was devoted to the quality of leadership. It observed:[3]

> *While some parts of the NHS have created and sustained the leadership cultures necessary for outstanding performance and the big service changes set out in this Long Term Plan, this is not yet commonplace. We also do not currently have a sufficient pipeline of highly skilled and readily deployable senior leaders – a 2018 survey by The King's Fund and NHS Providers found 8% of Executive Director roles were filled by an interim or vacant, while 37% of trusts had at least one vacant Executive Director post.*

The Plan committed to seeking to improve the "*leadership pipeline*" in part by a systematic approach to identifying, assessing, developing and supporting talent.

1.4 In 2020 NHS England published a long awaited People Plan.[4] This committed, among other steps, to providing "*refreshed support*" for leaders including seminars on inequalities and racial injustice, and action earning sets for senior leaders, and expansion of the number of placements available for talented clinical leaders, based in systems, focusing on improvement projects. By December 2020 the talent management process was to be updated to ensure "greater prioritisation and consistency of diversity in talent being considered" for senior leadership posts. By April 2021 a centralised online leadership hub of digital resources was to be made available.

1.5 The 2022 Messenger leadership review [see Schedule] observed that

> *over-emphasis on metrics can be burdensome and counter-productive. Where quality of care falls below what is required, the tone and outcome of regulatory visits can leave leaders feeling isolated and unsupported.*

It therefore recommended a change from a "*punitive*" model to a "*remedial*" one.

1.6 In June 2023, partly in response to the Messenger and Kark reviews, a 15 year, Long Term Workforce Plan was published,[5] in which NHS England committed to deliver talent, leadership and management improvement "*interventions*", and to maintain the NHS Graduate Training Scheme. "*compassionate*" leadership and workforce psychological well-being was to be incorporated in professional undergraduate training.

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[2] Anandaciva et al, *Leadership in today's NHS – delivering the impossible*, 18 July 2018 King's Fund https://www.kingsfund.org.uk/insight-and-analysis/reports/leadership-todays-nhs [downloaded 11 March 2024]

[3] NHS England, *the NHS Long Term Plan* 7 January 2019, https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/ ; Chapter 4.7 Leadership and talent management §4.50 https://www.longtermplan.nhs.uk/online-version/chapter-4-nhs-staff-will-get-the-backing-they-need/7-leadership-and-talent-management/ [viewed 14 May 2024]

[44] NHS England, *We are the NHS: Peop[e Plan 2020-21 – action for us all*, page 29, July 2020, https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf [viewed 14 May 2024]

[5] NHS England, *NHS Long Term Workforce Plan*, 30 June 2023, updated 22 April 2024 https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/ [viewed 14 May 2024]

1.7 It can be seen, therefore, that a number of steps have been taken to strengthen the pool and talents of NHS leaders. It remains to be seen how successful these measures are in achieving those aims.

1.8 I have observed over the years since the Mid Staffordshire NHSFT inquiries a pattern in which, shortly before a critical CQC report is published about a registered NHS provider, its Chief Executive departs. In discussions about the "*culture of blame*" said to affect frontline staff when serious incidents occur, it should not be forgotten that such a culture permeates local and national leadership in response to poor performance as well. In my view it is important to monitor whether the steps being taken to foster compassionate leadership extends appropriately to staff at leadership level within organisations.

1.9 Turning then to the effect of structural change I will outline at least some of the major structural changes that have taken place in recent times. A more detailed account of earlier changes appears in Annex J of my Mid-Staffordshire NHS Foundation Trust Public Inquiry report.

1.9.1 1973: The National Health Service Reorganisation Act 1973 introduced a structure consisting of 14 Regional Health Authorities (RHAs), responsible for planning health services in their region, 90 Area Health Authorities (AHAs), generally matching local authority boundaries beneath most of which were health districts administered by district management teams. GP services came to be managed by Family Practitioner Committees. The accepted culture was one of "*consensus management*".

1.9.2 1980: Following the Merrison Royal Commission's report of 1979[6] recommending a more streamlined structure, the Health Services (DHAs) Act 1980 disbanded AHAs and established 192 District Health Authorities (DHAs). Family Practitioner Committees were given independent status. The DHAs controlled the management of hospitals and other so-called Units of Management. The Commission upheld the concept of "consensus management".

1.9.3 1984: Organisational reforms were introduced following the Griffiths report, [7] which famously remarked that

> *If Florence Nightingale were carrying her lamp through the NHS today, she would be searching for people in charge.*

Griffiths recommended that the levels of decision-making should be reduced: general managers should be appointed to every Unit of Management with all decisions being taken at that level unless the Chair of the DHA could justify it being taken at a higher level. At national level there should be a Health Services Supervisory Board chaired by the Secretary of State, and an NHS Management Board at arm's length from ministers.

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[6] Merrison et al, *Report of the Royal Commission on the NHS*, https://sochealth.co.uk/national-health-service/royal-commission-on-the-national-health-service-contents/ Chapter 20 §20.15 [accessed 10 April 2024]

[7] Griffiths, *NHS Management Inquiry* October 1983 https://sochealth.co.uk/national-health-service/griffiths-report-october-1983/

In other words Griffiths endorsed a move towards "*general management*" a concept explicitly rejected only 4 years previously by the Royal Commission It is sometimes overlooked that Griffiths was emphatic that clinicians should be more closely involved in management for which purpose they needed adequate support to enable them to spend less time in meetings. He also emphasised that it was vital to find out how well the service was doing locally by obtaining the experience and perceptions of patients and the community from Community Health Councils among others.

1.9.4 1989: the Health Service Supervisory Board was wound up.

1.9.5 1990: the NHS Management Board became the NHS Executive. NHS Trusts were established by the National Health Service and Community Care Act 1990. This Act sought to set up an "*internal market*" in which there would be "*purchasers*" of healthcare (DHAs and GP fundholders) and "*providers*" (hospitals, community and ambulance services). designed to make the State an enabler of health services rather than the supplier. The structure of the NHS consisted of Regional and District Health Authorities, Family Health Services Authorities, and NHS Trusts. Hospitals were encouraged to apply to become NHS Trusts and thereby gain self-governing status. Each Trust would have a board of directors with a chair appointed by the Secretary of State and would employ its own staff. Arrangements for the supply of services between health service bodies were to be in the form of "*NHS contracts*", which had the peculiar characteristic of giving rise to no contractual liabilities or rights in law. They were sometimes called "*service level agreements*". Purchasers were free to change providers if they could find a better service that way. Any dispute was to be referred to the Secretary of State for determination.

1.9.6 There were three "*waves*" of NHS Trusts. In the first, 57 NHS Trusts were created along with 306 GP fundholders. In the second, a further 192 Trusts appeared in the year 1992-93, and by April 1994 there were 419 NHS Trusts and some 9,000 GP Fundholders.

1.9.7 1995: Following the White Paper *Working for Patients* in 1989, the Health Authorities Act 1995 abolished RHAs (by then reduced to eight from 14) and replaced them by eight regional offices; DHAs were merged with Family Health Service Authorities to form 100 Health Authorities.

1.9.8 1997: The newly elected Labour Government committed itself in a White Paper, *The New NHS, Modern, Dependable*, to maintaining the purchaser provider split, but to abolishing the "*internal market*"

1.9.9 1998: NICE was established to assess costs and benefits of interventions and make recommendations.

1.9.10 1999: Primary care groups were established to enable GPs, and other healthcare professionals jointly to commission health and care services for local communities. The Health Act 1999 formalised the establishment and powers of these groups of which there were 481. In the wake of the Bristol Inquiry [see above] the Act also established the Commission of Health Improvement (CHI) with power to review the governance arrangements in every NHS organisation in England and Wales and to carry out

investigations of providers where suspected serious service failings had occurred. Thus for the first time there was independent regulation of clinical performance.

1.9.11 2000: *The NHS Plan* introduced payment by results.

1.9.12 2002: *Delivering the NHS Plan* proposed the introduction of Foundation Trusts, followed through on payment by results, and proposed changed regulatory bodies. The National Health Service Reform and Health Care Professions Act 2002 brought about a number of changes:

(a) Strategic Health Authorities (SHAs) were created out of the RHAs which were abolished.

(b) Primary Care Trusts (PCTs) were established in place of Primary Care Groups to be responsible for commissioning most health services, including primary health services, and for improving public health: originally there were 330 such Trusts.

(c) Patient and Public Involvement Forums were established for each NHS Trust, with power to enter and view prescribed premises, to provide independent advocacy services and to provide advice and information to service users

(d) A "*super regulator*" for healthcare professions was established: the Council for the Regulation of Health Care Professionals.

1.9.13 2002: CHI merged with National Care Standards Commission to become the Commission for Healthcare Audit and Inspection (CHAI), a non-departmental public body. It did not use its formal name but called itself the Healthcare Commission (HCC).

1.9.14 2004: The Health and Social Care (Community Health and Standards) Act 2003 formally introduced the NHS Foundation Trust, a new form of NHS entity and established Monitor (formally called the Independent Regulator for Foundation Trusts) to authorise, monitor and regulate them. The Government's policy intention was that all NHS Trusts should focus on achieving the financial and other standards required to become Foundation Trusts.

1.9.15 2005: The Government's *Creating a patient-led NHS* and *commissioning a patient-led NHS* required PCTs to introduce patient choice into elective care, and to involve local clinicians more in service design. The number of PCT's was reduced to 152 to align better with local authorities and they were also required to separate the provider responsibilities (i.e. in primary care) from their commissioning of secondary care. A *Transforming Community Services Policy* proposed separating community services, a policy which swiftly reversed until reinstated in 2009 (see below).[8]

[8] NHS Confederation PCT Network, *The legacy of primary care trusts*, June 2011 https://www.nhsconfed.org/system/files/2021-07/The_legacy_of_PCTs.pdf [downloaded 7 March 2024]

1.9.16 2008: "*World Class Commissioning*" was introduced as a concept, but largely abandoned after 2 years.

1.9.17 2009: CHAI/HCC was abolished and replaced by the Care Quality Commission under the Health and Social Care Act 2008 as the regulator of health and social care services. CHAI's last act was the publication of a critical report into the Mid-Staffordshire NHS Foundation Trust.[9]

1.9.18 2012: Following on from *Liberating the NHS*,[10] published in 2010 and subjected to fierce debate, the Health and Social Care Act 2012, often dubbed "*the Lansley reforms*", abolished SHAs and PCTs, transferring commissioning functions to Clinical Commissioning Groups with effect from 2013. The system regulator was renamed Monitor and given defined strategic as well as regulatory oversight duties.

At the time the DH offered the public a diagrammatic description of the health and care system:

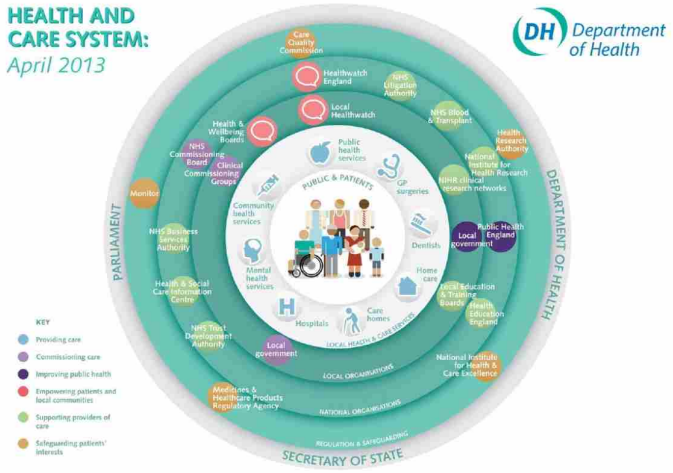

Figure 1 Diagram on DH website until 23 August 2022

1.9.19 2014: The NHS *Five Year Forward View*[11] called for better integration of healthcare services, and the NHS was required to develop local plans to achieve this.

1.9.20 2017: The NHS *Next Steps on the five year forward view*[12] put forward national priorities for the next two years.

1.9.21 2017: Health Services Investigation Branch (HSIB) was established as a non-statutory body funded by DHSC and hosted by the NHS Trust Development Authority. It was tasked

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[9] HCC, *Annual report 2008/09*, 14 July 2009, HC 718 https://assets.publishing.service.gov.uk/media/5a7c6ac6ed915d6969f44b6b/0718.pdf [Downloaded 9 April 2024]. See page 21 for a summary of their investigation into Mid Staffordshire NHSFT.

[10] DH, *Equity and Excellence: Liberating the NHS*, July 2010, Cm 7881 https://assets.publishing.service.gov.uk/media/5a7c5299e5274a2041cf33af/dh_117794.pdf [accessed 10 April 2024]

[11] https://www.england.nhs.uk/publication/nhs-five-year-forward-view/

[12] https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/

with a specific programme of safety investigations into maternity services, as outlined in an action plan, *Safer Maternity Care*, starting in April 2018, with full national coverage achieved in April 2019. HSIB was also tasked with a national patient safety investigation programme, under which it would select incidents to investigate applying a detailed set of criteria. The approach was to be one in which blame and liability are not attributed.

1.9.22 2019: The NHS *Long Term Plan*[13] set ambitions for outcomes to be achieved over the following 10 years, in part by giving people more control over their own health and integration of care provision, but also by a workforce implementation plan to expand the number of staff to meet growing need. The Plan also announced the creation of an NHS Assembly to bring together selected organisations and individuals to advise NHS England and NHS Improvement on implementation of the Plan.

1.9.23 2019: NHS England was directed[14] to create Primary Care Networks [PCNs] to bring GP practices together by contract with other health and social care staff to provide more integrated services to their local populations. The Directions have been amended 10 times since then.[15] There are about 1,250 PCNs, and the vast majority of GPs have agreed to join one, because of the financial incentive to do so. It was intended that there would be a Network Contract each financial year until March 2024 with evolving requirements.[16] PCNs would typically cover a population of 30,000-50,000 patients. Groups of PCNs would be within the area of an Integrated Care System (ICS) which would serve populations of between 1 and 3 million.[17]

1.9.24 2020: The UK formally left the European Union.

1.9.25 2020-2021: The pandemic led to emergency provisions throughout the service.

1.9.26 2022: The Health and Care Act 2022 gave legal confirmation to organisational changes that have previously been occurring in "*shadow*" form, following the Long Term Plan, by the abolition of clinical commissioning groups [CCGs] and their replacement by Integrated Care Boards and Integrated Care Partnerships.

1.9.27 2023: The Government's *2023 Mandate to NHS England*[18] set the NHS four priorities for the year 2023/24: cutting NHS waiting lists and recovering performance, supporting the workforce through training, retention and modernisation, delivering recovery through use of data and technology, continuing to deliver the Long Term Plan to transform services and improve outcomes.

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[13] https://www.longtermplan.nhs.uk

[14] The Primary Medical Services (Directed Enhanced Services) Directions 2019 https://assets.publishing.service.gov.uk/media/6409c44f8fa8f556125db9ab/primary-medical-services-des-directions-2019.pdf

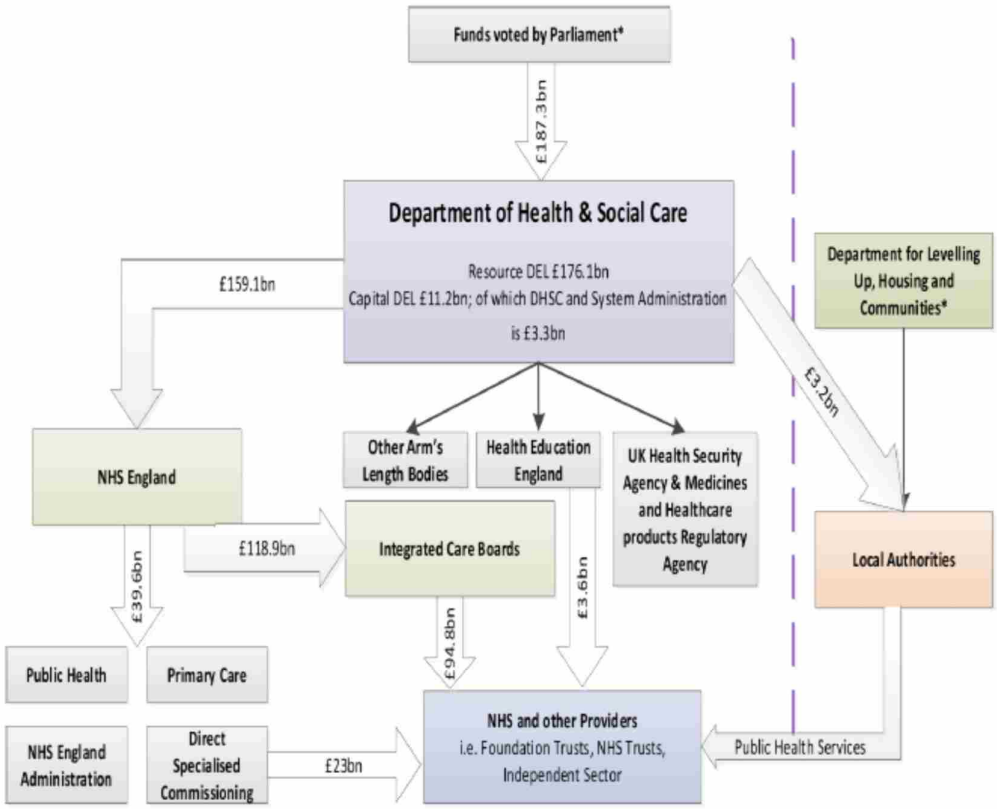
[15] The current Directions are The Primary Medical Services (Directed Enhanced Services) Directions 2023. https://assets.publishing.service.gov.uk/media/6426c51bfbe620000c17da41/primary-medical-services-directed-enhanced-services-directions-2023.pdf These have already been amended twice

[16] See *Network Contract Directed Enhanced Service Contract specification 2022/23 – PCN Requirements and Entitlements* 30 September 2022 NHS England PR1963_i§1.5 https://www.england.nhs.uk/wp-content/uploads/2022/03/B1963_i_Network-Contract-DES-Specification_171022.pdf

[17] This description is taken from *Primary Care Networks (PCNs)* 16 February 2023, updated 17 November 2023 NHS England https://www.england.nhs.uk/long-read/primary-care-networks-pcns/ [accessed 6 March 2024] [the full report is not accessible digitally]

[18] https://www.gov.uk/government/publications/nhs-mandate-2023/the-governments-2023-mandate-to-nhs-england#mandate-objectives 15 June 2023

1.9.28 2023: Following the previous reorganisations the DHSC described the organisation of the NHS diagrammatically as follows:[19]



The arrows in this diagram denote the direction of funding; accountability is intended to flow in the opposite direction.

1.9.29 2023: NHS Digital, NHS X merged into NHS England.

1.9.30 2023: NHS Long Term Workforce Plan, setting out a 15 year strategy, was published, and described by the NHS Chief Executive as "*one of the most seminal moments in our 75 year history*".[20] I have described some of its features above.

1.9.31 2023: Health Services Safety Investigations Body (HSSIB) was established under the Health and Care Act 2022 and took over from the HSIB. It has the power to choose which incidents to investigate in accordance with published criteria but may be directed to investigation an incident by the Secretary of State. HSSIB is, subject to exceptions such as a court order, prohibited from disclosing information held by it for investigations and

[19] DHSC, *Annual Report and Accounts 2022-2023*, 25 January 2024, HC 33. https://assets.publishing.service.gov.uk/media/65b236c81702b10013cb1289/DHSC-Annual-report-and-accounts-2022-2023-web-accessible.pdf [downloaded 5 April 2024]

[20] https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/ 30 June 2023, updates 4 January 2024

breach of this is a criminal offence. The maternity safety investigations programme was transferred to CQC, because the 2022 Act made no provision for it.

1.9.32 2024: A helpful textual description of the system as it works now can be seen in a House of Commons Library briefing, published in 2023, summarising the landscape following the introduction of Integrated Care Systems.[21] A recently published critical analysis by the think tank, Reform[22] also contains a good description, and suggests that a radical restructuring is required if the NHS is to be effective in delivering a modern, holistic, patient-centred health improvement service.

1.10 It can be seen that the system has been subjected to virtually continuous systemic change for the last 20 years. Many if not most of the changes have been intended to distance the operational delivery of health services from the Government, while maintaining a centralised overall control of the funding. Arguably none of them have succeeded in such an ambition. Different Governments, different Secretaries of State, have had different visions and priorities for making the NHS better and have often turned to structural changes as much as operational or cultural change. It is not surprising that Governments pay this amount of attention to an organisation which is responsible for a large proportion of their expenditure and is also regarded by the public as one of the most important aspects of British life. However, this has all allowed a culture or looking upwards for authority and initiative rather than more locally and autonomously.

1.11 Revisiting my report (principally at chapter 19), the numerous major changes in process then reflected the constant tensions between on the one hand:

(a) the desire to steer and control the system's direction of travel and public expenditure;

(b) the need to prevent deficiencies for which Ministers will be held accountable in Parliament and by the public;

(c) the wish to enable them to take credit for successes,

and on the other:

(a) the belief that change and improvement are made more easily by more autonomous entities remote from Whitehall;

(b) a desire to promote patient choice and competition as a driver for improvement;

(c) the view that delegation and distance allow Ministers to disclaim responsibility when things go wrong;

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[21] Powell, *The structure of the NHS in England*, 10 July 2023, House of Commons Library, https://researchbriefings.files.parliament.uk/documents/CBP-7206/CBP-7206.pdf [viewed 14 May 2024]

[22] Reform Reimagining Health Council, *Close Enough To Care A new structure for the English health and care system*, 2 April 2024, https://reform.uk/publications/close-enough-to-care-a-new-structure-for-the-english-health-and-care-system/ [downloaded 5 April 2024]

(d) A wish to protect the system from the vagaries of politically led demands.

1.12 In my report I quoted Professor Sir Ian Kennedy and his pithy summary of these tensions:

> *… while the politicisation of the NHS is in some respects a good thing, as political commitment to the magnificent enterprise of the NHS is positive, there is an obvious tendency for the system to reflect the political ambitions of the current Government. The lack of continuity in terms of vision and the desire to tinker with the structure of the NHS may be a consequence. Whilst the NHS is separate from Government at a constitutional level, the Government of the day does not treat it as an independent entity. The distinction between the Department of State and the NHS is at best blurred*

1.13 Major structural reorganisation carries with it a number of risks:

1.13.1 Difficulty in evaluating the impact of any measure;

1.13.2 Implementing major structural change inevitably reduces focus on other priorities including the interests of service users, continuity of service and protection of standards during the process of change;

1.13.3 Preoccupation with employment prospects at all organisational levels and effect on staff morale; any restructuring results in at best changes in employer for many staff, and, at worst redundancy; many will be faced with an abrupt removal from projects in which they have invested considerable personal capital.

1.13.4 Potential loss of corporate memory;

1.13.5 Lack of clarity and consistency in messaging and understanding about the strategic purpose of the change;

1.13.6 For front-line staff such changes can mean increased separation from and reduced understanding of their leadership and their priorities.

1.14 It was for this reason I recommended [recommendation 286] that impact and risk assessments, answering specific questions about the merit of any proposed major restructuring, should be published and debated before the proposal is implemented.

1.15 The Reform report cited above identified two key "*pathologies*" in the healthcare system:

> *…. it is possible to discern its two key pathologies: a high degree of centralism and fragmentation between health creating and sickness services. These two features are closely linked – a top-down approach, particularly in the healthcare system, serves as a key barrier to driving the local flexibility necessary to truly integrate commissioning and delivery*

1.16 While agreeing with that observation I would add that the" *top-down*" structure makes it more difficult for recommendations for cultural and other forms of change to be implemented at local level because of the constant pressure on and focus on the

requirements of the centre. At the same time, the centre tends to prioritise financial control and easily measured process targets over the more diffuse requirement of culture.

1.17 The Reform report advocates a radical change by phasing out NHS England, restricting the role of national organisations to be enablers rather than controllers of the system, and by making local systems democratically accountable to their local populations. This is not the place to comment on some of the detail involved in that argument, but I consider that local organisations which look outwards towards their community's and patients' needs are more likely to be able to introduce a culture change than those which have to look "*up*" to the centre.

1.18 Returning to the question, it is inevitable that constant structural change makes it extremely difficult to follow through the implementation of inquiry recommendations. The task of analysing implementation and follow through of recommendations which a Government or other relevant body has publicly accepted is a challenging task. Even where there is a genuine desire to adopt recommendations this can be made more challenging when the recommendation was addressed to a structure which has been changed or no longer exists. I was personally faced with the challenge of how to phrase recommendations appropriately when I had inquired into events in a structure that existed in 2009, but in writing my report in 2012 was seeking to address them to a system in the course of changing in response to the Lansley reforms.

2. Openness, transparency and candour

Taking into account your chosen definitions, explanation of concepts and the work of previous inquiries, please explain what the expected standards were in the NHS (a) in 2015 and (b) now for: i. openness; transparency; and candour.

2.1 Overview

What I understand these terms to mean is as follows:

- Openness

In the Mid-Staffordshire NHS Foundation Trust Public Inquiry I gave as a short definition of this the following[23]

the proactive provision of information about performance, negative as well as positive

This term is intended to convey an attitude in which those working in the healthcare system, and the system itself, are open about strategy and policy development, and involve service users, staff and the public in its formulation. There should be a similar openness about the availability of services, their performance and outcomes, and in relationships with individual service users and staff. An important feature of openness is that reports should present both the positive and the negative aspects of any issue: whether it be about the risks and benefits of particular treatments or the success or failure of a strategic initiative.

- Transparency

In the Public Inquiry report I gave the following definition of this term:

the provision of facilities for all interested persons and organisations to see the information they need properly to meet their own legitimate needs in assessing the performance of a provider in the provision of services

All information about this highly important public service should be accessible to all who have an interest in receiving it. Relevant information should be in the public domain unless there are compelling contrary reasons. Where information is confidential to a service user, the dissemination of that information should be for them to decide not the system which purports to be serving them.

- Candour

In my report, candour, while naturally being a feature of openness and transparency, has a more specific meaning:

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[23] Public Inquiry Report Chapter 20 §20.1

the volunteering of all relevant information to persons who have, or may have, been harmed by the provision of services, whether or not the information has been requested, and whether or not a complaint or a report about that provision has been made.

The term is intended – and is now generally understood – to refer to an obligation of individual healthcare professionals, all of whose codes of conduct impose it on them, and of healthcare organisations as entities, which have the like obligation under regulatory law.

2.2 Clearly there is an overlap between these terms and therefore in the implications each has for both professionals, the organisations which employ them, and the system as a whole. One way of distinguishing between them is that candour is directed towards individual patients, transparency is directed outwards from the organisation and its professionals to the external world in general and openness is the receptiveness of the organisation and the professionals working within it to external information and influence. However the requirements of all three concepts are also relevant to the management of internal relationships between staff.

2.3 2015

2.3.1 The nature of the obligations in 2015 and now can be gleaned from my comments on the implementation of inquiry recommendations concerning this area above. There is, or should be, little difference in the nature and spirit of these obligations whether considered from the perspective of 2015 or now. There may be a difference in how these obligations are understood and in the way they are implemented. However, any healthcare professional, and any health service manager should have been aware in 2015, and should be aware now, of these obligations.

2.3.2 That year was 14 years after the Bristol inquiry report, 2 years after the publication of the Mid-Staffordshire Public Inquiry report and was when the Freedom to Speak Up review was published. All these reports advocated the principles of openness, transparency and candour, and added increasing detail to the leadership, professional and system required to support them. The Kirkup report into the scandal at Morecambe Bay was published in March 2015 and once again emphasised the importance of these principles. For example Dr Kirkup recommended the relevant NHSFT immediately apologise to patients and families for what had befallen them [recommendation 1] and required the Trust to review and reinforce its policies with regard to openness, honesty and candour [recommendation 11]. Recommendation 24 expressly commended the duty of candour and recommended that it be enhanced by the involvement of patients and families in incident investigations. It is a challenging, and perhaps not a proportionate, task, to unearth from the archives all editions of guidance on this topic applying to all professionals and organisations, but in the face of the material I cite here, all of which was a matter of constant discussion at healthcare conferences, in medical, managerial and policy publications, and guidance, it is inconceivable that any trained healthcare professional, manager or leader was unaware of the expectations and need for openness, transparency and candour at any time from 2015 to date.

2.3.3 To recap on the regulatory regime in place in 2015:

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including regulation 20 (the duty of candour) came into force the day they were made: 8 November 2014. Amendments were laid before Parliament on 1 January 2015 and came into force on 1 April 2015.[24]

- Regulation 20(1) required organisations to act in an open and transparent with "*relevant persons*" in relation to any treatment and care provided to a service user.

- Where what was called a notifiable safety incident [the definition of which was modified in the 2015 amendment] occurred, the duty of candour required specified steps to be taken with regard to disclosure of information, investigation and apologies. It was potentially an offence to fail to comply with these requirements.

- It was made an offence to provide misleading information with regard to prescribed categories of information, with effect from 26 March 2015.[25]

- Guidance for professionals, NHS boards and leaders on their respective duties of candour was widely available.

2.4 Revalidation

2.4.1 It is relevant to note here the revalidation regime was already in place to address potential concerns about doctors, by introducing a regular regulatory check on their fitness to remain in practice In 2016 NHSE published guidance indicating the way in which information about a doctor's practice should be deployed and shared in the NHS.[26] This referred to the Responsible Officer Regulations[27] which provided for the appointment in virtually every NHS organisation one or more Responsible Officers [ROs]. Among their responsibilities were:[28]

(a) *to ensure that the designated body carries out regular appraisals on medical practitioners in accordance with paragraph (3);*

(b) *to establish and implement procedures to investigate concerns about a medical practitioner's fitness to practise raised by patients or staff of the designated body or arising from any other source;*

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[24] The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015 reg 10 https://www.legislation.gov.uk/uksi/2015/64/contents/made?regulation-10-2

[25] Care Act 2014 section 92; The False and Misleading Information (Specified Care Providers and Specified Information) Regulations 2015 SI 988 as amended [downloaded 3 March 2024]

[26] *Information flows to support medical governance and responsible officer statutory function*, NHS England 11 August 2016 https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2016/10/cg-information-flows-oct16.pdf [downloaded 2 February 2024]

[27] *The Medical Profession (Responsible Officers) Regulations 2010* SI 2010 No 2841, made on 24 November 2010 and coming into effect on 1 January 2011 https://www.legislation.gov.uk/uksi/2010/2841/made, as amended by *The Medical Profession (Responsible Officers) Regulations 2013* SI 2013 No 391 https://www.legislation.gov.uk/uksi/2013/391/made/data.pdf [downloaded 2 February 2024]

[28] Ibid regulation 11

(c) *where appropriate, to refer concerns about the medical practitioner to the General Council.*

2.4.2 In undertaking the role ROs must have regard to guidance issued by the Secretary of State and the National Clinical Assessment Service of the NHS Litigation Authority [now Resolution) and NHS England.[29] In relation to employed doctors within their area of responsibility ROs have to confirm they have the relevant qualifications and experience, and monitor their conduct and performance by identifying issues arising from general performance information and ensure the relevant body takes steps to address such issues. Where necessary for this purpose they must initiate investigations and

> *ensure that procedures are in place to address concerns raised by patients or staff or the designated body or arising from any other source.* [30]

2.4.3 One of the principal responsibilities of the RO is to oversee the revalidation process, part of which is to inform the General Medical Council when requested every 5 years whether the officer

(a) *recommends that the practitioner is fit to practise*;

(b) *cannot recommend that the practitioner is fit to practise; or*

(c) *requires more time in which to make a recommendation,*

and in each case the responsible officer must give reasons. [31]

2.4.4 The GMC has powers to investigate any concerns raised by this process which can lead to regulatory action. It is, however, to be noted that, according to the guidance:[32]

> *On a routine basis the responsible officer is only required to share information about a doctor's fitness to practice with the GMC. The responsible officer is not under any duty, routinely, to share information about a doctor's fitness to practice with any other person. This contrasts with certain ad hoc situations where a responsible officer may need to exchange information about a doctor's practice with a range of other people in the interests of protecting patient safety.*

2.4.5 However *"other persons and organisations"* have a duty of cooperation with them to support them perform their responsibilities.

2.4.6 The guidance distinguishes between the limits of routine exchange of information and "*ad hoc*" situations where the RO needs to exchange information in the interests of

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[29] Ibid regulation 15, 18, and amended y 2013 BI 391 regulation 4(2)(3)

[30] Ibid regulation 16, in particular regulation 16(4)(c).

[31] *The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012* (as amended) SI 2012 SI 2685 as amended, coming into effect on 3 December 2012 Schedule paragraph 6(5) https://www.legislation.gov.uk/uksi/2012/2685/data.pdf downloaded 2 February 2024

[32] *Information flows to support medical governance and responsible officer statutory function* (above) page 6

protecting patient safety. Very detailed flow charts, toolkits and guidance are given for how and with whom information is to be exchanged in routine and ad hoc situations.

2.5 2024

2.5.1 The acceptance of the need to observe these principles is essentially the same in 2024 as it was in 2015. The only differences are that there has been more time for leaders to implement systems and develop a culture in which these become a reality, but sadly further examples of the consequences of not doing so have come to light. The direction of regulation and guidance has remained consistent with what has gone before,

2.5.2 It is a challenging task to unearth previous editions of publications on the internet, but as examples, updated guidance on regulation 20 was published by CQC in 2021,[33] and June 2022,[34] and by the Government in 2020.[35] The professional regulators' codes of conduct continue to remind registered professionals of their obligations. The regulatory, and ethical framework for these principles and how to comply with them has remained essentially the same since 2015.

2.5.3 It is unlikely that any NHS leader is unaware of these principles, but an example of the awareness of the obligations of transparency and candour, even in providers that have been rated "*Inadequate*" by CQC, can be seen in a recent report of an inquest. The Trust involved was reported to have issued a statement and an apology admitting specified shortcomings in care, midwives accepted in hindsight that they could have done more to save a baby's life, and a consultant offered the opinion that there was a significant chance of a better outcome if correct treatment had been started earlier.[36]

2.6 Conseqiences of non-compliance

2.6.1 Sadly there have been too many reminders of the consequences of non-compliance for patients and their families and repeated recommendations to the same effect as those previously made by other inquiries:

(a) The Gosport Inquiry;

(b) The Paterson Inquiry;

(c) The Ockenden Review;

(d) The Independent Medicines and Medical Devices Safety Review;

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[33] https://www.cqc.org.uk/news/stories/updated-guidance-meeting-duty-candour

[34] https://www.cqc.org.uk/sites/default/files/2022-12/20220722-duty-of-candour-pdf-version-FINAL-2.pdf

[35] https://www.gov.uk/government/publications/nhs-screening-programmes-duty-of-candour/duty-of-candour

[36] BBC News, *Derby midwives apologise at baby boy's inquest*, 7 March 2024 https://www.bbc.co.uk/news/uk-england-derbyshire-68496789 [accessed 10 March 2024]

(e) The scandal of maternity and neonatal services in East Kent.

2.6.2 There have been many inquiry recommendations suggesting improvements to support the principles:

(a) The Williams review of the use of manslaughter prosecutions in medical cases pointed [recommendation 5] to the need to protect material prepared by doctors, and by inference any healthcare professional, for the purposes of their reflective practice, following fears that prosecutors and regulators would demand disclosure of this material and then use it against the professional. This was thought to deter candour and learning from error.

(b) The Gosport Inquiry's recommendation 4 which suggested more needed to be done to ensure families were enabled better to understand events, and recommendation 17 which urged more clarity for families of the role of the confusing matrix of organisations and their investigations.

(c) The Paterson Inquiry which recommended improvement in the information given to patients about consultants' practice.

(d) The Ockenden Review's recommendations for improving the means by which providers listened to the concerns of patients, the information given to women in the consent process and about investigations.

(e) The IMMDS's recommendation of an immediate Government apology, which was issued, and a central database to collect key details of implanted devices.

(f) Dr Kirkup, who in spite of an entirely appropriate warning against adding to the list of previous detailed recommendations in the East Kent review, did suggest consideration of a legal duty not to deny, deflect or conceal information. While this is still under consideration, the recommendation itself underlined, if emphasis was required, the importance of transparency and openness for the service and its users.

2.7 Challenges to implementation

Although the principles of openness, transparency and candour can be said to have been embedded, problems with implementation have been highlighted. For example the use and risk of gross negligence manslaughter prosecutions and professional disciplinary action is said to inhibit candour on the part of healthcare professionals when they know they have made a mistake which may have had serious consequences. The troubling case of Dr Bawa Garba raised the issues in both these contexts, and I, among others, went on record in suggesting that the current law and/or its use were flawed.[37] The case of Dr Sellu caused a similar stir. The issue has been considered by two reviews, the Williams

[37] For a useful timeline and links to news reports on this case see BMJ online *The Bawa Garba case*, https://www.bmj.com/bawa-garba [accessed 10 March 2024].

Review[38] and the Hamilton Review.[39] An interesting recent academic article associates a punitive attitude towards medical error leads to a toxic culture of fear. It suggests that consideration be given to replacing this with a restorative justice approach combining a more supportive and rehabilitative approach with remedies for victims.[40]

[38] Williams, *Gross negligence manslaughter in healthcare – The report of a rapid policy review*, June 2018, https://assets.publishing.service.gov.uk/media/5b2a3634ed915d2cc8317662/Williams_Report.pdf [downloaded 10 March 2024]

.[39] General Medical Council, Independent Review of Gross Negligence Manslaughter and Culpable Homicide, June 2019, https://www.gmc-uk.org/-/media/documents/independent-review-of-gross-negligence-manslaughter-and-culpable-homicide---final-report_pd-78716610.pdf [downloaded 10 March 2024]

[40] Farrell et al, *Gross Negligence Manslaughter in Healthcare: Time for a Restorative Justice Approach?*, 27 April 2020, Medical Law Review 2020 Aug 1; 28(3): 526-548 https://pubmed.ncbi.nlm.nih.gov/32462185/ [downloaded 10 March 2024]

3. **How, if at all, did these expected standards differ between clinical and non-clinical staff (a) in 2015 and (b) now?**

If there is or has been a difference, please explain why? Do these expected standards differ in the setting of a neonatal unit? If yes, how? If no, should they?

For the reasons given in the previous section, I do not consider there has been any material change in these expected standards over the course of time. The source of the expectation does differ between different clinical disciplines, and between clinical and non-clinical staff.

3.1 Doctors

3.1.1 The source of the professional duty of candour and of openness and transparency for doctors is the GMC Code of Conduct and guidance.

3.1.2 In 2015 the version of Good Medical Practice in force was that published in March 2013.[41] This remained in force with minor amendments until 30 January 2024. This required doctors to be:

> *Open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should*
>
> *a. put matters right if that is possible)*
>
> *b. offer an apology*
>
> *c. explain fully and promptly what has happened and the likely short-term and long-term effects.*

3.1.3 This document also contained the somewhat general injunction at paragraph 65

> *You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*

and at paragraph 68

> *You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.*

3.1.4 Earlier provisions in the Safety and Quality Domain [paragraphs 22 to 30] required participation in systems of quality assurance and improvement, helping keep patients safe by contribution to confidential inquiries, adverse event recognition and reporting of

[41] GMC, *Good Medical Practice*, 29 March 2013, in effect from 22 April 2013 https://www.gmc-uk.org/-/media/gmc-site/ethical-guidance/archived-guidance/good-medical-practice-english-2013---2024.pdf [downloaded 10 March 2024]

adverse incidents relating to medical devices and drug reactions. Paragraph 24 required doctors to promote and encourage a culture that allows all staff to raise concerns openly and safely. Paragraph 25 required prompt action if patient safety was or might be seriously compromised

3.1.5 Coexisting with Good Medical Practice was guidance on raising concerns about patient safety, first published in 2006, and withdrawn in March 2012. This was a precursor to the requirements of the Freedom to Speak Up agenda; it, said nothing about candour with the patient as such, but focussed on reporting concerns about safety or putting the matter right personally. At the time of the Mid Staffordshire NHSFT Public Inquiry the GMC's evidence confirmed that a duty of candour was in place.[42] in June 2015 the GMC, jointly with the NMC, introduced detailed practical guidance on the professional duty of candour.[43] This document referenced a 2014 joint statement[44] by the Chief Executives of all the statutory regulators of healthcare professionals reminding their registrants of the duty of candour. It reiterated the duty in similar terms to those quoted above.

3.1.6 The 2024 version of Good Medical Practice [45] contains the following relevant requirements:

(a) With regard to patients, the doctor must, among other requirements

(i) Give them the information they need in a way they can understand including options for treatment and the risks and benefits;

(ii) Listen to patients encouraging an open dialogue and responding honestly to their questions;

(iii) Ensure information given to them is clear accurate and up to date, based on the best available evidence;

(iv) Be open and honest about any interest they may have which may affect the way treatment is proposed, provided or prescribed;

(v) Consider the needs and welfare of people who may be vulnerable, and offer them help if it is thought their rights are being abused or denied;

(vi) Act promptly on any concerns held about a patient, or someone close to them, who may be at risk of abuse or neglect, or is being abused or neglected.

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[42] Inquiry report paragraph 22.127

[43] GMC *Openness and honesty when things go wrong: The professional duty of candour*, 29 June 2015, updated 15 March 2022 https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/candour---openness-and-honesty-when-things-go-wrong [downloaded 10 March 2024]

[44] Joint statement by the Chief Executives of statutory regulators of healthcare professionals 9 October 2014, https://assets.pharmacyregulation.org/files/joint_statement_on_the_professional_duty_of_candour.pdf [downloaded 14 May 2024]. This was signed by the Chief Executives of the General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Nursing and Midwifery Council, and Pharmaceutical Council NI.

[45] GMC, *Good Medical Practice,* 22 August 2023, in effect from 30 January 2024 https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors [downloaded 10 March 2024]

(b) If things go wrong the doctor must

(i) Be open and honest with patients, and if they have suffered harm or distress, follow the GMC Guidance on the duty of candour, with regard to putting matters right, apologising, explaining and reporting incidents.[46]

3.2 Nurses

3.2.1 At the time of the Mid Staffordshire NHSFT Public Inquiry the NMC's Code of Conduct stated:[47]

> *You must act immediately to put matters right if someone in your care has suffered harm for any reason.*
>
> *You must explain fully and promptly to the person affected what has happened and the likely effects.*
>
> *You must cooperate with internal and external investigations.*

3.2.2 This code was in place from 1 May 2008 to 30 March 2015.

3.2.3 The NMC published a new code of conduct in January 2015, effective from 31 March 2015, which was updated on 10 October 2018, and remains current.[48] This repeated the duty in similar terms.

3.3 Other Healthcare Professionals

3.3.1 The 2014 joint statement by professional regulators has been referred to already. Each of those regulators would have included consistent descriptions of the duty of candour in their codes. In its original standards published by the HCPC, effective from 26 January 2016,[49] there was a requirement to be open and honest with service users and apologise, to take action to put things right and to make sure an appropriate explanation is given.

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[46] GMC/NMC *Openness and honesty when things go wrong: the professional duty of candour*, 29 June 2015, updated 15 March 2022 [downloaded 10 March 2024]

[47] Inquiry report paragraph 22.128; NMC *The Code: Standards of conduct, performance and ethics for nurses and midwives* (1 May 2008), NMC, paras 54–55 https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-old-code-2008.pdf [downloaded 10 March 2024]

[48] NMC, *The Code - Professional standards of practice and behaviour for nurses, midwives and nursing associates* 29 January 2015, updated 10 October 2018 https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf [downloaded 10 March 2024]

[49] https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-conduct-performance-and-ethics.pdf?v=637171211260000000 [downloaded 10 March 2024] there are likely to have been an earlier set of standards but to date I have been unable to locate them.

3.3.2 The HCPC webpage contains a section on the duty of candour, last updated on 26 January 2022.[50] The Council has revised its standards to come into effect on 1 September 2024.[51] These set out a process for registrant to follow when things go wrong and refers to the need to alert the employer to what has gone wrong and to follow relevant internal processes. The standard in connection with the duty of candour has remained essentially the same, but with added detail.

3.4 Healthcare providers

3.4.1 Government guidance[52] about the duty of candour regulation has existed since its inception.

3.4.2 NHS England guidance on engaging patients, families and staff following a patient safety incident, dated August 2022,[53] outlines in detail four steps of engagement to be followed with patients, families and staff following an incident. This is part of the implementation of the Patient Safety Incident Framework. It sets out powerful arguments for this type of engagement [emphasis in the original]:

> *There are compelling moral and logical arguments for engaging with those affected by a patient safety incident and involving them in a learning response.*
>
> *First, those affected by a patient safety incident may have a range of needs (including clinical needs) as a result and these must be met where possible. This is part of our duty of care. Meeting people's needs not only helps alleviate the harm experienced, but also helps avoid compounding that harm…*
>
> *Second, engaging with those affected by a patient safety incident substantially improves our understanding of what happened, and potentially how to prevent a similar incident in future. Patients, their family members, and carers may be the only people with insight into what occurred at every stage of a person's journey through the healthcare system. Not including those insights could mean an incomplete picture of what happened is created. Similarly, staff have important contributions to make about their experience of the incident and the working environment at the time and should be supported to share their account.*

3.5 Neonatal units

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[50] https://www.hcpc-uk.org/standards/meeting-our-standards/raising-concerns-openness-and-honesty/the-duty-of-candour/ [accessed 10 March 2024]

[51] https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/revised-standards/ [accessed 10 March 2024]. https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/revised-standards/what-is-changing/ helpfully shows the textual changes from the current standard 8, which addresses the duty of candour. For a complete list see https://www.hcpc-uk.org/globalassets/standards/standard-of-conduct-performance-and-ethics/revised-standards-2023/list-of-changes---revised-scpes.pdf [downloaded 10 March 2024]

[52] https://www.gov.uk/government/publications/nhs-screening-programmes-duty-of-candour/duty-of-candour [updated 5 October 2020]

[53] NHSE, *Engaging and involving patients, families and staff following a patient safety incident*, August 2022. PAR1465 https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf [downloaded 10 March 2024]

3.5.1 Clearly the duty of candour as formulated in the regulations applies as much to neonatal units and care as any other treatment and care. Also clearly the patients are particularly vulnerable: they cannot speak for themselves, their mothers may be suffering from postnatal issues which reduce their ability to represent their babies interests in the immediate aftermath of birth, and parents and families will in any event be experiencing considerable emotional stress. Therefore the context in which all the values and duties considered in this report have to be complied with is particularly demanding.

3.5.2 It is instructive to look at the inspection framework for neonatal units published by CQC in July 2016.[54] Inspectors were enjoined to consider a number of questions including:

> *Do staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally?*
>
> *Are people who use services told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result?*
>
> *When things go wrong, are thorough and robust reviews or investigations carried out? Are all relevant staff and people who use services involved in the review or investigation?*
>
> *How are lessons learned, and is action taken as a result of investigations when things go wrong?*
>
> *How well are lessons shared to make sure action is taken to improve safety beyond the affected team or service?*

3.5.3 The guidance referred inspectors to the Serious Incidents Framework 2015 and the Duty of Candour is the relevant professional standard.

3.5.4 Fast forwarding to 2024, the Government, in its response to Dr Kirkup's report on East Kent maternity services, set out a long list of actions to be taken in this area, many of which are designed to ensure that families are listened to and involved in investigations with compassion and sensitivity, and to ensure better and more effective teamwork and learning. One of Dr Kirkup's recommendations focused on non-compliance with the duty of candour. In its response the Government observed:

> *…it's clear from this report that some of those involved in East Kent did not adhere to the duty of candour. This left families without answers or even feeling deceived by those working in a system in which they placed so much trust. This should never be the case for anyone who is seeking answers from those who have responsibility for caring for them.*
>
> *We received feedback during our discussions with the families and some other stakeholders that there is concern and a perception that trusts and individuals are*

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[54] CQC, *Inspection framework: NHS Acute (specialist children's hospitals) – Core Service: Neonatal services*, July 2016 https://www.cqc.org.uk/sites/default/files/20160713_NHS_specialist_core_service_inspection_framework_neonatal_services.pdf [downloaded 10 March 2016]

being hindered in their ability to be fully transparent by legal advice, or through reputation management strategies. It is also clear to us from those discussions that a duty of candour is not satisfied just by a single, one-off candid conversation, but should underpin the whole of the process of supporting and working with families, at every stage.

3.5.5 They referred to the then recently published NHS 3 year delivery plan for maternal and neonatal services[55] and its requirement for open and honest reporting and sharing of information, regular reviews of quality, and listening to and acting on feedback from staff. The 3-year delivery plan contained commitments to support staff to work with professionalism, kindness, compassion, and respect, and to implement an NHS wide approach for all incidents to support families with a compassionate response and to ensure learning. This was followed by detailed objectives and metrics. The Government promised to consider the recommendation to create a statutory duty not to deny, deflect or conceal information from families or other bodies in conjunction with a response to Bishop John Jones's Hillsborough report. The Government's response[56] did not arrive until 13 December 202313 December 2023 in which

(a) The Government signed the Hillsborough Charter which among other thigs, commits signatories *"to approach public scrutiny including inquiries and inquests with candour, in an open, honest and transparent way, making full disclosure of relevant documents, material and facts*", and to avoid seeking to defend the indefensible;

(b) They committed to introduce into the Victims and Prisoners Bill [still before Parliament] the establishment of a permanent Independent Public Advocate to support bereaved families after a major incident.

(c) They rejected the recommendation to introduce a general duty of candour for all public officials [often called the Hillsborough Law and incorporated in the (lapsed) Public Authority Accountability Bill

(d) The Government did, however, also announce an intention to review of the application of the duty of candour, transparency and openness in healthcare

3.5.6 This evidence suggests that throughout the period 2015 to date CQC has had an inspection regime which in theory will detect systemic non-compliance with the letter and spirit of the duty of candour requirements. Despite that, egregious failures such as that at East Kent have occurred in maternity and neonatal services. It should be recalled that Dr Kirkup reviewed the standard of that service as provided from 2009 to 2020. Therefore by no means all the deficiencies he identified were historic. As promised in the

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[55] NHS England, *Three year delivery plan for maternity and neonatal services*, March 2023 https://www.england.nhs.uk/wp-content/uploads/2023/03/B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf [downloaded 10 March 2024]

[56] Home Office, *A Hillsborough legacy: the government's response to Bishop James Jones' report*, December 2023, https://www.gov.uk/government/publications/hillsborough-disaster-report-government-response/a-hillsborough-legacy-the-governments-response-to-bishop-james-jones-report-accessible#foreword [viewed 14 May 2024]

Government's response to Bishop James Jones's report, it has now commenced a review of the statutory duty of candour.[57]

3.6 Conclusion

In conclusion it is my opinion that while the requirements of openness, transparency and candour rights apply to all healthcare provision, neonatal services should have a relentless focus on them in this regard because of the extreme vulnerability of the patients and moreover of their families. There can be no stronger case for compassionate listening, involvement and interaction with families of a patient than where that patient is an extremely ill neonate. Frankly if the service cannot get this right that setting, one might ask is there any hope of effective implementation anywhere?

[57] DHSC, *Duty of candour review*, 16 April 2024, https://www.gov.uk/government/calls-for-evidence/duty-of-candour-review/duty-of-candour-review [viewed 14 May 2024]

4. **How and by whom were these expected standards for openness, transparency and candour monitored, if at all, in 2015?**

Do you consider that was effective? How are these expected standards monitored now? Do you consider that is effective? As far as possible please provide reasons for these changes and for any views you express, in particular by reference to financial resources, availability of staff, training, regulation and other issues as you see fit.

4.1 As with all other standards of service in the NHS, there are several levels and types of monitoring:

- The individual healthcare professional
- The organisation providing the service
- The system oversight and licensing organisations
- Professional regulators
- The system regulator

4.2 Monitoring by healthcare professionals and organisations

4.2.1 The first level at which compliance with these duties should be monitored is among the professionals themselves. Each has a duty to ensure that the duty is complied with and to raise a concern if they perceive this is not occurring. I have already described the expectations and standards as defined by the professional regulators. These standards have been expressed in different ways since 2015, but essentially all derive from the regulations enacted in 2014. While it is tolerably certain that any professional trained in this country will have been aware of these obligations, the essence of which predated the regulations and my report, "*club*" type cultures could well have survived the criticism in the Bristol Inquiry report, which would deter professionals working within them from speaking up. It is instructive to return to Professor Kennedy's descriptions of what he meant by "*club culture*":[58]

(a) *"an imbalance of power, with too much control in the hands of a few individuals"*

(b) *A "club culture", to which you either belonged or not"*

(c) Younger clinicians were made to feel that

there was a sense of a club, to which one belonged or from which one was excluded. This meant, for instance, that it was difficult to raise what were

[58] Bristol Inquiry Final report page 2 §8, page 68, chapter 5 §21; page 165, chapter 12 §30; page 201 chapter 15 §16

considered to be legitimate concerns. The style of management had a punitive element to it; and there was no properly effective system for dealing with concerns: everything depended on people rather than systems. Also, the environment was not such as to make 'speaking out' or 'openness' safe or acceptable.

(d) In other evidence

Mr Boardman told the Inquiry that a career depended on someone's 'fit' within the 'club', rather than performance, and that any challenge to policy was perceived as disloyalty.

4.2.2 Professor Kennedy gave influential evidence[59] to the Mid Staffordshire NHSFT Public Inquiry based on his experience at Bristol. In truth, as has been pointed out by Mannion et al,[60] culture in a hospital setting is multifaceted, and there may indeed be no overall organisational culture, good or bad, as opposed to multiple cultures, held by different professional groups, departments, or other groupings. As they say:

Paying greater attention to the multilayered and multifaceted complexity underlying the term—and recognising that many and varied cultural subgroups make up our healthcare organisations—opens new avenues for understanding the deeply social and discursive nature of complex organisations.

4.2.3 They warn, in my view correctly, that a focus on culture should not lead to ignoring other aspects of organisational life such as skill, attitude, responsibility and governance. However culture, in the sense of the "*way we do things around here*" particularly when that "*way*" differs between groups, can obstruct change and improvement. Thus a keen young trainee who wishes to draw a possible safety defect to the attention of their consultant may be advised by colleagues, or the consultant personally, not to do so, the advice being accompanied by an implied or express suggestion that to do so will harm their career, or that it is not worth the trouble. Equally, where the cultural approach of the team is to discuss such issues freely then the trainee is likely to be encouraged to raise the matter. The working supposition in the NHS leadership has been that leadership can change and improve this sort of culture. Thus a 2017 NHS Improvement training programme, still offered as part of the resources supporting the NHS People Promise,[61] asserted:

The culture of an organisation or a system shapes the behaviour of everyone in it…. Leadership, particularly compassionate and inclusive leadership, is the key to enabling culture changes that allow NHS organisations to:

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[59] Mid Staffordshire NHSFT Public Inquiry report vol 2 chapter 19 page 1273 §19.24, vol 3 chapter 24. Page 1546 §24.4- page 1547 §24.4

[60] Mannion and Davies, *Understanding organisational culture for healthcare quality improvement*, 28 November 2018, BMJ 2018;363 https://www.bmj.com/content/bmj/363/bmj.k4907.full.pdf [downloaded 11 March 2024]

[61] NHS Improvement/King's Fund Cultural Leadership Programme , *Why is culture important,* September 2017, IT 0/17 https://www.england.nhs.uk/wp-content/uploads/2021/06/01-NHS101-02-Improvement-Mini-Guide-Why-100417-I.pdf [downloaded 11 March 2024]; see https://www.england.nhs.uk/culture/ accessed 11 March 2024

- *deliver high quality care and value for money*
- *ensure that staff are free to show compassion, speak up and continuously improve in an environment free from bullying, where there is learning, quality and effective system leadership…*

4.2.4 Leadership can certainly prevent or contribute to preventing an open and transparent culture developing, as illustrated by the Stafford Hospital scandal. However, while appropriate leadership is a necessary component, it is not sufficient. It is quite possible for a "*club*", closed culture to exist in one department, while the opposite flourishes elsewhere, and if left unchecked and unchallenged, it can spread like a virus. The Morecambe Bay report described a relatively isolated community with little chance of joint working with others and giving rise to an increased risk of practice "*drifting away*" from standards applied elsewhere. Moving forward seven years to the same author's report on East Kent, we find difficulties arising out of the merger of three hospitals with each unit retaining its own policies. Over time a disconnect between frontline staff and senior management persisted with a lack of engagement of staff in the process of change required. There were also divisions between senior and other midwifery staff, and between midwifery and consultant staff. The description of divisive, hierarchical and oppressive behaviours in chapter 4 of the report is instructive of what produces a "toxic" culture. The report concluded:

> *What we saw and heard was that it was when clinicians were exposed to the behaviour of senior colleagues that their standards began to slip. The influence of role models, those whose positions more junior staff would aspire to fill one day, can be significantly greater than classroom teaching. If those role models themselves display poor behaviours, the potential is there for a negative cycle of declining standards.*

4.2.5 This cycle of poor behaviours and declining standards was again seen by CQC in its series of inspections of University Hospitals Sussex, NHS Foundation Trust. In 2021 it rated maternity and surgery services there as "*Inadequate*" for safety because of inadequate staffing and training, management of safety incidents and learning, and failure to value and listen to staff.[62] For example surgery staff told inspectors they had not ever seen a member of the executive in the department and did not feel concerns could be raised without fear.

4.2.6 That cycle is challenging to break because this sort of behaviour becomes normalised, particularly if the senior leadership will not encourage or listen to concerns raised by patient or the staff. The same pattern can be seen on the Ockenden report on Shrewsbury and Telford Hospital NHS Trust,[63] where there appeared to be a marked reluctance on

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[62] CQC, *Royal Sussex County Hospital Inspection Report*, 10 December 2021 https://api.cqc.org.uk/public/v1/reports/27b2982f-c189-4e2b-968e-4712772f831e?20221219084458 [downloaded 12 March 2024] see https://www.cqc.org.uk/location/E0A3H/reports [accessed 12 March 2024] for subsequent reports which show an improvement.

[63] Ockenden et al, *Maternity Services at the Shrewsbury and Telford Hospital NHS Trust – our first report following 250 clinical reviews*, 10 December 2020, https://assets.publishing.service.gov.uk/media/5fd20f8be90e076637bb5a24/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

the part of midwives to involve consultants, and likewise a reluctance on the part of consultants to listen to midwifery staff and similar difficulties between junior and senior staff. A key recommendation was the need for multidisciplinary training.

4.2.7 These reports and others do not suggest that all organisations and their staffs have succeeded in creating or maintain a culture and observance of openness, transparency and candour reaching into all their domains. I remain, however, convinced, that personal and organisational application of the lessons in this regard in the Mid-Staffordshire reports and the Freedom to Speak Up review, together with the personal and leadership behaviours those lessons require would produce the desired healthy culture. The tools created in 2014/5 and more recently provide the means of following the relevant principles and monitoring the standards achieved. These have been described elsewhere but to list some of them:

(a) All registered doctors, nurse, and possible registered ancillary professions can and will reflect on their practice routinely for appraisals, and in response to safety incidents in which they are involved.

(b) Most work in teams whom they can personally encourage to adopt the behaviours which support openness, transparency and candour.

(c) There may be opportunities to share experiences with colleagues in safe surroundings, such as a Schwartz round.[64]

(d) If their workplace is not conducive to this culture, they will know that, and can seek advice and support from sympathetic colleagues, professional associations, training organisations, and Freedom to Speak Up Guardians.

(e) If criticised for following their professional obligations, they can refer to their codes of conduct as supporting their actions and should be protected from adverse internal management action by this.

(f) If they want to speak up or insist on candour, but are obstructed, they can report the issue to a number of prescribed external organisations, including reporting hostile registered colleagues to their regulator.

4.2.8 So what is it which gets in the way of all this occurring consistently? The starting point has to be human nature. Self-confident professionals, who have spent years training for their roles, will not always welcome even constructive criticism, unless they have been trained, preferably experientially in a multi-disciplinary setting, to do so. An added pressure can be the threat of adverse consequences, whether it be of intervention by the employer, a regulator, or, worse still, the police. There can be peer pressure from colleagues explicitly or implicitly suggesting that pursuing a concern will not help a career.

[64] Schwartz Rounds are a technique supported by the Point of Care Foundation for bringing staff from all disciplines together to discuss shared problems in a safe, well organised but informal environment. See https://www.pointofcarefoundation.org.uk/our-programmes/staff-experience/ [accessed 8 April 2024]

4.2.9 Organisations

There are many methods available by which senior leaders and boards can promote and monitor cultural behaviours in their organisations:

(a) One of the best and most direct methods is by leaders, executive and non-executive, having a visible presence among frontline workers, listening and responding to what they say, but also to what patients and visitors have to say.

(b) Leaders can role model the expected behaviours, call out colleagues at all levels for unacceptable behaviour, show their own willingness to be candid about error, and in the final resort take steps to remove from the organisation those who will or cannot adopt this way of working.

(c) There are many sets of data which, singly or together, give a picture of the cultural health of an organisation and its various units or departments. Among these are, in no particular order, the staff survey [see above for some of the relevant questions on this issue], incident reports, outcome data, patient feedback, complaints, trainee surveys. When considering data it is also important to look for the negative as well as the positive side. there can be a temptation to see an increase in a positive response rate from, say 49% to 51% as good news, forgetting the numbers behind the negative responses, even if they are in a minority. This is particularly true of responses about bullying and other oppressive behaviour: the fact that such intolerable conduct exists at all is the bad news and requires action not complacency. The effective use of data should also not mask the significance that should often be attached to single incidents. One case can show multiple points of systemic failure which need to be addressed, in preference to hunting for someone to blame for an error.

(d) In a number of places in my report[65] I recommended better use of information from peer review, both by regulators and internally. Where there have been concerns open and transparent organisations can commission peer reviews and publish the results. Too often in the past such reports have not been published thus contributing to a cultural deterioration and may not even have reached the board of the organisation. However peer review should be a regularly used internal tool with colleagues supporting each other in learning lessons and improving their practices.

[65] See Mid-Staffordshire NHSFT Public Inquiry Report chapter 11 page 999 §11.279, page 1000 §11.283; pages 1006-1007 recommendations 49, 52; chapter 12 page 1031 §12.78, page 1049 recommendation 225; chapter 17 chapter page 1195 § 17.105, page 1199 recommendation 101; chapter 21 page 1400, 1433-1434 §§21.96-21.102, page 1438 recommendation 13

(e) A number of other methods are suggested by NHS England in the "*15 Steps Challenge*", first developed in 2012, and revised in 2017.[66] National Maternity Voices produced a version of this specifically for maternity services in 2022.[67] This advocates a method for ward visits, and steps which can be used by staff, as well as commissioners and regulators. Other measures are described in NHS England's 2022 best practice guidance.[68]

(f) What are the obstructions preventing these and other advocated methods of cultural improvement being effective? At organisational and leadership level, all the personal pressures mentioned above apply as much to managers and leaders as they do to the frontline professional. Added to that are the internal or external pressures to meet specified performance expectations. At Stafford Hospital at the time the pressure was to tidy things up to maximise the prospects of becoming a Foundation Trust. Today the pressures are more likely to derive from the excess of demand for services over the supply of resources of staff, equipment and even suitable premises. It is notable that some organisations appear to cope better with these pressures than others, and I suspect these are the ones who adopt and wholeheartedly embrace the principles and values considered above. For an analysis which will, I suspect, ring true for many working in the NHS, see Roger Kline's critical analysis of leadership in the NHS, as he saw it in 2019.[69]

> *The NHS is a complex archipelago of national and local bodies, networks, commissioners, regulators and providers. Though the Health and Social Care Act 2012 changed the relationship between Ministers and Arm's Length Bodies, it made little change to how the NHS workforce was managed and led with a continuing stream of expectations, requirements, targets, inspections and funding decisions which fundamentally influence workforce culture and leadership. The dominant cultures within those national bodies deeply influence behaviours and priorities at local level.*

(g) Unfortunately there are far too many reports of systematic victimisation of whistleblowers. A very recent news report[70] has brought together a number of examples of this from which the deduction has been drawn that there is a systemic approach to the suppression of undesired reports of concerns and

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[66] NHS Institute for Innovation and Improvement, *The Fifteen Steps Challenge – Quality from a patient's perspective*, May 2012 https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/15-Steps-Challenge-toolkit.pdf [downloaded 12 March 2024]; NHSE, *The Fifteen Steps Challenge – Quality from a patient's perspective; An inpatient* toolkit, 2017 Gateway ref 07422 https://www.england.nhs.uk/wp-content/uploads/2017/11/15-steps-inpatient.pdf [downloaded 12 March 2024]

[67] https://nationalmaternityvoices.org.uk/toolkit-for-mvps/mvps-in-action/gathering-feedback/15-steps-for-maternity/ [accessed 12 March 2024]

[68] NHSE, *Safety culture – learning from best practice*, 14 November 2022 PAR1760 page 9 [see above for link]

[69] Kline, *Leadership in the NHS*, 23 September 2019 BMJ Leader 2019;3:129-132 https://bmjleader.bmj.com/content/leader/3/4/129.full.pdf [downloaded 12 March 2024]

[70] Eastham, Rayner, *The four-step 'playbook' the NHS uses to break whistleblowers*, 15 May 2024 The Telegraph, https://www.msn.com/en-gb/news/other/the-four-step-playbook-the-nhs-uses-to-break-whistleblowers/ar-BB1msjwU [downloaded 16 May 2024]; Banfield, *Doctors are being 'forced' to choose between their patient safety and their careers*, 15 May 2024, The Telegraph https://www.telegraph.co.uk/news/2024/05/15/doctors-forced-to-choose-between-patient-safety-and-careers/ .Professor Banfield is chair of the BMA Council.

the isolation of those who raise them. It is suggested that the methods fall into fall stages:

(i) Investigation of the whistleblower rather than the problem they raise;

(ii) Bullying and intimidation of the whistleblower by management and/or colleagues;

(iii) "weaponisation" of referrals to professional regulators;

(iv) Disciplinary action including demotion or dismissal.

(h) It is true to say that I have seen examples of all these in my professional practice and in the course of the Freedom to Speak Up review and in more recent cases reports of which I have seen. Not all such allegations are necessarily easy to prove or would, on forensic examination, be justified. Employers often respond to such allegations by pointing to their duty to address misconduct or incompetence even if the employee has made a public interest disclosure. Sometimes it is suggested that such a disclosure has been made to pre-empt disciplinary action. It can be a complex matter to untangle the rights and wrongs of such issues, particularly when the underlying evidence can span long periods of time and numerous issues and personnel. However, while I have seen no evidence of any deliberate system driven intent to suppress whistleblowing in this way, I have little doubt that each of these methods has been used in some cases. In any event, whether or not any particular allegation is true, collectively they constitute a serious deterrent to staff thinking of raising a serious concern, particularly if it involves a criticism of colleagues or their organisation's leadership.

4.3 System regulation and oversight

4.3.1 The regulatory system in place in 2015 and today has been sufficiently described elsewhere. In terms of system oversight, this responsibility used to be shared between Monitor, NHS Trust Development Authority and NHS England. Now all aspects of licensing and commissioning are overseen by NHS England alone. However the structural changes did not change the messaging or the substance of the support available. Much of this has been described above. There has been no shortage of policy documents, guidance, and support available in this area. There can be little doubt that the message coming from the centre was and is that suppressing openness, transparency and candour is unacceptable. Unfortunately, though, from the perspective of the executive leadership of provider organisations, this message has been received along with imperatives about other forms of performance, such as waiting time initiatives, discharge rates, and financial control. Local leaders sometimes report feeling threatened in terms of their careers if these other expectations are not met. Kline observed this in 2019 analysis [see above]:

> *… command and control are deeply embedded in senior NHS leadership behaviours. Status and funding are used to either support or, in effect, beat up local leaders, confusing bullying with accountability. The behaviours of national bodies largely shape what local leaderships do or don't do. Where NHS trusts are highlighted as being particularly innovative, effective and safe employers, it is unclear how many of them became so because of top-down support.*

4.3.2 A 2019 article[71] described the national cultural structure in these terms [internal references omitted]:

> *The NHS is governed by a politicised bureaucracy which is strongly influenced by 19 quasi-autonomous nongovernmental organisations (quangos)]. The largest of these is NHS England among whose 15 directors, only two are medical doctors, and neither is an NHS clinician. There is one nurse on the Board of Directors]. Britain has proportionately fewer doctors and important healthcare technologies than other similar countries, and this is not all attributable to decreased overall NHS funding. Rather, it is the culture of the NHS bureaucracy that does not value the diagnosis and management of serious diseases as much as equity of access, diversity considerations, A&E waiting times and public health campaigns. This may reflect the priorities of quangos not informed by the expertise of NHS clinicians.*

4.3.3 I have already referred to the tenure of executive directors in the NHS. Appointments of CEOs and chairs are under the control of or heavily influenced by NHS England. Their regional directors are responsible for overseeing their performance and offering support where needed.[72] Relations tend to become particularly tense over financial management leading to discontent being reported in trade publications. For example in April 2023 the Health Service Journal was reporting[73] allegations of "*intimidating conversations*" and difficult demands amid concerns about quality and safety. Whether or not the specific allegations in reports like this are accurate or even fair, they contribute to a climate in which executives can fear for their jobs if their focus is not almost exclusively on the demands of the centre. Inevitably this can detract in particularly challenged organisations from their obligations of openness and transparency.

4.4 Professional regulators

4.4.1 It is not clear to me that monitoring of healthcare professionals in this regard has been sufficient, if present at all. These regulators are only empowered to act if a complaint about an individual practitioner is made to them, and sufficient evidence is produced to justify an investigation. The professional regulators rarely work in tandem with each

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[71] Stevenson, Moore, *A culture of learning for the NHS*, Journal of European CME 28 May 2019 vol 8 1613862 https://www.tandfonline.com/doi/full/10.1080/21614083.2019.1613862 [downloaded 12 March 2024]

[72] For details see https://www.england.nhs.uk/about/regional-area-teams/

[73] Anderson, *Deficit trusts face 'intimidating conversations' and orders to hold down staffing*, 25 April 2023 Health Service Journal https://www.hsj.co.uk/finance-and-efficiency/deficit-trusts-face-intimidating-conversations-and-orders-to-hold-down-staffing/7034689.article [accessed 12 March 2024]

other; as a result they may not be aware of a consistent level of concern about professional behaviour at a particular organisation, or of a context in which a whistleblower's conduct is being treated differently from that of other members of staff. Unlike the system regulators they are unable to launch intelligence-led investigations proactively. Unfortunately, therefore, it is often only after a disaster has been uncovered that multiple cases raising fitness to practise issues come to light. They remain restricted by their governing legislation with regard to their scope of action and are largely confined to being reactive rather than proactive.

4.4.2 However professional regulators are now bringing together more systematically their observations of the system to analyse negative and positive effects on the registered workforce. For example, the GMC has analysed cases coming to it[74] to examine whether they support various hypotheses and previous findings. This analysis has suggested that there is a higher rate of referral from employers of doctors in some groups than for others. The reasons for this are said to be:

(a) *Doctors in diverse groups do not always receive effective, honest, timely feedback because of a reluctance to have difficult conversations… meaning concerns may not be addressed*

(b) *Some doctors are provided with inadequate induction and/or support in transitioning to new social, cultural and professional environments.*

(c) *Those doctors working in isolated or segregated roles or locations lack exposure to learning experiences…*

(d) *Some leadership teams are remote and inaccessible, not seeking the views of less senior staff and not welcoming challenge, which can allow divisive cultures to develop.*

(e) *Some organisational cultures respond to things going wrong by trying to identify who to blame rather than focusing on learning. This creates particular risks for doctors who are 'outsiders'.*

(f) *In groups and out groups exist in medicine including relating to qualifications… and ethnicity (including within BME populations). Members of in groups can receive favourable treatment and those in out groups are at risk of bias and stereotyping.*

4.4.3 GMC also publishes an annual barometer of the workplace experiences of trainees, alongside its State of Medical Education and Practice in the UK report.[75] The 2023 barometer identified "*vicious cycles relating to workforce pressures and lack of time for patients, development, and personal wellbeing*". It is observed that "*moral injury is*

[74] GMC, *Compendium of GMC published findings relating to Fitness to Practice rates (2022)*, November 2022 https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/medical-practice-statistics-and-reports/fitness-to-practise [downloaded 12 March 2024]

[75] https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk [accessed 12 March 2024]

distress caused by people acting, or seeing others act, in a way which goes against their values and moral beliefs." The report outlines a series of actions the GMC believes could mitigate these challenges. However as a regulator it has no power to ensure these are implemented, and I have seen no evidence of how, if at all, it takes such matters into consideration when considering FTP cases.

4.4.4 NMC is reviewing[76] FTP cases referred from Shrewsbury and Telford NHS Trust, East Kent University Hospitals NHS Foundation Trust, and Nottingham University Hospitals NHS Trust with the aim

> *To understand how we took context factors into account when handling these cases and making our decisions, we wanted to learn whether we have been taking a fair and proportionate approach to cases relating to major inquiries and also whether there is more we can do to support more system-wide response to addressing failings in maternity services. The report is being finalised in 2023-2024.*

4.4.5 This might suggest that little has previously been done to participate in a system-wide approach, but the Inquiry might wish to ask the NMC for any evidence to the contrary.

4.5 The system regulator – CQC

4.5.1 It is a truism to say that regulation by inspection will generally only detect deficiencies in retrospect. Such regulation only prevents them if the regulated conscientiously set out to comply with the regulatory standards all the time, rather than immediately in advance of an anticipated inspection. The guidance issued by CQC relevant to openness, transparency and candour has been described sufficiently above. The best evidence of what the CQC has found at individual providers is to be found in their inspection reports, all of which are available on their website. Each year an analysis identifies the themes and trends that emerge from those inspections in the Annual State of Care report.

4.5.2 Unsurprisingly the 2014/15 report[77] suggested that there was generally an awareness of the Duty of Candour regulation, especially among senior managers, but that specific structures were "*starting*" to be put in place to support compliance. CQC had also seen "*positive evidence*" of trusts meeting their obligations, including providing an apology about serious incidents. CQC urged providers to develop better data that was accessible to all, and to be open and transparent about mistakes and learning from them. They reported that increased reporting of serious incidents [a 10% increase between 2013 and 2014] was the result of some hospitals responding to the need to have a more open and transparent safety culture, after my report. However,

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[76] See NMC, *Annual Fitness to Practice Report 2023,* July 2023 https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/2023-reports-and-accounts/annual-report/nmc-annual-fitness-to-practise-report-2022-2023.pdf [downloaded 12 March 2024]

[77] CQC, State of Health Care and Adult Social Care in England 2014/15. 14 October 2015 HC 483 https://webarchive.nationalarchives.gov.uk/ukgwa/20160426095732/http://www.cqc.org.uk/content/state-care-201415 [downloaded 12 March 2024]. All State of Care reports from 2010 to 2023 appear on the National Archives website https://webarchive.nationalarchives.gov.uk/ukgwa/*/http://www.cqc.org.uk/stateofcare

> *We have found, however, significant inconsistencies in the reporting and investigation of incidents, as well as delays and poor escalation of issues. We have seen poor governance processes where risks were not reported and monitored effectively. In some cases the safety and risk system itself was not fit for purpose as it only looked at trust level and did not reveal local issues. This sometimes left the governing bodies unaware of incidents.* [78]

4.5.3 The report stated that trusts rated as "*Outstanding*" had staff who actively participated in audits and were confident in reporting incidents, whereas in Trusts rated as "*Inadequate*" or "*Requires Improvement*" there was limited cross-learning between and within departments, and low awareness of improvements. Salford Royal NHS Foundation Trust, one of two rated "*Outstanding*" that year was highlighted as being "*particularly good at learning from incidents and patient experiences"* with a "*strong, open reporting culture."*[79]

4.5.4 The 2015/16 State of Care report again identified effective leadership and a positive, open culture to be important drivers of improvement.[80] It emphasised once again the importance of strong leadership with a good understanding of their service, available to listen to their staff and service users, and clear and transparent about concerns that need to be addressed:[81]

> *Often the most important factor behind improvement is the culture of an organisation. Where the leadership team are visible and actively promote an open and positive culture at all levels, this can drive positive change. Staff feel supported and listened to, with the reasons for any changes to the service clearly communicated*

4.5.5 It is sobering to note that what was then called Western Sussex Hospitals NHSFT was rated "*Outstanding*" that year and that staff there were noted to be encouraged to have an open and honest attitude towards reporting mistakes and incidents.[82] By 2023 one of its hospitals had been downrated to "*Requires Improvement*" overall and for safety and leadership.

4.5.6 By 2023 the State of Care report[83] was reporting with greater emphasis concerns about patient safety. In particular it was noted that staff across health and care sectors were using the CQC's feedback facility to report stress, burnout, and issues of poor leadership and negative workplace cultures, with concerns and complaints being ignored or suppressed. Given the plethora of recent independent reports, it was not surprising that

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[78] 2014/15 report page 72

[79] 2014/15 report page 67

[80] CQC, *State of Health Care and Adult Social Care in England 2015/16* 12 October 2016 HC 706 https://webarchive.nationalarchives.gov.uk/ukgwa/20161107112611/https://www.cqc.org.uk/content/state-of-care [downloaded 12 March 2024]

[81] Ibid pages 35-36

[82] Ibid page 78

[83] CQC, *The state of health and social care in England 2022/23*, 19 October 2023, HC 1871 https://www.cqc.org.uk/sites/default/files/2023-10/20231030_stateofcare2223_print.pdf [downloaded 19 April

CQC had particular concerns about safety in maternity services, 49% of which were rated either "*Inadequate*" or "*Requires Improvement*". The report noted in particular concerns that a higher percentage of maternity staff from ethnic minorities experienced harassment, bullying or abuse from colleagues than among white groups. One example given was:

> *"They will say about a [white] staff member, 'that person is so passionate', and when it's a Black person, it is called 'aggressive'. Even though those two people are saying the same thing.*

At the same time it reported serious deterioration in staff working conditions, as indicated by the NHS staff survey referred to above. The principal cause seems to have been staff shortages, not helped by the effects of stress caused by overworking, lack of safety from bullying and other forms of oppressive behaviour. The impact on service users was that the remaining staff felt that this was affecting their ability to provide safe and effective care. Staff told CQC in focus groups that they wanted a culture in which they felt listened to and had regular opportunities for feedback.

4.5.7 These reports show, and my own experience throughout this period would confirm, that the CQC integrated the requirements of openness, transparency and candour into its inspection regime and guidance. It succeeded in inspecting every acute hospital trust at least once in the next few years and would have checked their compliance in each of them, with varying results as described above. However, problem areas have remained and in some places, there has been serious deterioration. Therefore there is a lack of stability in this regard. CQC has performed its functions in promoting and regulating compliance with these principles, but there are obvious limitations on CQC's ability to detect poor standards everywhere all of the time. As in so many areas regulation is not a sufficient safeguard: effective committed leadership together with trained, properly resourced and values driven staff are also essential components.

5. Healthy culture

Please answer questions (a) to (d) below and as far as possible, please provide examples from the NHS and elsewhere, drawing on your own and other reports or research as you see fit;

(a) *How would you define a healthy culture within (a) the NHS and specifically (b) any NHS neo-natal unit?*

(b) *How has this definition changed over time and why? Please focus in particular on the period 2015 onwards and the present day.*

(c) *How do you identify an unhealthy culture in the NHS and what source(s) of information would you use?*

(d) *Are there accepted practices for improving an unhealthy culture in the NHS*

5.2 Introduction

5.2.1 Michael West, a renowned authority on cultural and leadership issues in the NHS has defined "culture" as:[84]

> *a set of shared, taken-for-granted implicit assumptions that members of an organisation hold and that determines how they perceive, think about and react to things [ref omitted] In other words, it is 'the way we do things around here'. Every interaction in an organisation both reveals and shapes its culture – for instance, how staff talk to or about patients, and how they talk to each other. Culture reflects what an organisation values: quality, safety, productivity, survival, power, secrecy, justice, humanity and so on. If there are strong values of compassion and safety, new staff learn the importance of caring and safe practice. If they observe senior staff behaving aggressively or brusquely, they assimilate that. In short, if we want to improve care, we must focus on nurturing appropriate cultures.*

5.2.2 As must be apparent from this report up to this point, the NHS is not short of perceptions and descriptions of the desired culture, or of tools with which to assess it. It might be argued that the plethora of policy papers, guidance from multiple sources causes confusion rather than enlightenment. There is a similar risk in seeking to add to these definitions of adding just one more statement with which all can agree. The tensions between the perceived merits of autonomous local organisation and of central direction make cohesion challenging.

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[84] West et al, *Developing collective leadership for health care*, May 2014, King's Fund page 5 https://assets.kingsfund.org.uk/f/256914/x/9406fe95d0/developing_collective_leadership_2014.pdf [downloaded 13 March 2024]

5.2.3 There is a tendency among NHS organisations individually to insist on creating their own set of values and cultural expectations even if on analysis are not very different from each other. If evolved through genuine "*bottom-up*" involvement, discussion and decision, in other words is evolved through what West describes as "*collective leadership*", then the process has the merit of promoting a collective identity and ambition. Taken too far, however, this can result in a reluctance to accept innovation and external ideas: the reluctance within NHS organisations to adopt something not created internally is well known. Arguably, if the NHS is to be a national organisation, or even a national healthcare movement, the values and principles of its, the NHS's, culture should be understood and accepted in the same terms everywhere within in it. That way everyone working in the NHS should be able not only consider themselves to be part of that national operation, but can all share the same understanding of what that means. It is for that reason that I recommended in the Mid Staffordshire Public Inquiry that all staff should be required to enter into an express commitment to abide by NHS values and the Constitution [recommendation 7]. I have already commented above that I am unsure that this recommendation was ever fully implemented.

5.3 *How would you define a healthy culture within (a) the NHS and specifically (b) any NHS neo-natal unit?*

5.3.1 Currently all NHS Trusts have their own set of values, which are required as the starting point for creating and maintain the culture they aspire to. Taking at random three NHSFT's:

(a) University College London Hospital NHSFT's values are *"Safety, Kindness, Teamwork, Improving"*.

(b) University Hospitals of Morecambe Bay NHSFT states that its *"key values*" are *"compassion, dignity, respect, and working in partnership with our staff, volunteers and partner organisations."*, although at another page the values are said to be "*we are compassionate, we are respectful and inclusive, we are ambitious, we are open, honest and transparent."*[85]

(c) University of Birmingham Hospital NHSFT's values are "*Kind, Connected, Bold"*.[86] Ironically the outgoing Ombudsman, Rob Behrens, is reported to have criticised this Trust's Board and regulators for failing to tackle what he described as "*disgraceful*" behaviour, in, among other things, referring 26 doctors to the GMC because they had raised concerns.[87]

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[85] https://www.uhmb.nhs.uk/our-trust/about-our-trust ; https://www.uhmb.nhs.uk/our-trust/we-are-uhmbt/purpose-vision-and-values [both accessed 13 March 2024]

[86] https://www.uhb.nhs.uk/about/vision/ [accessed 13 March 2024]

[87] Campbell, *NHS ombudsman warns hospitals are cynically burying evidence of poor care*, 17 March 2024, The Guardian https://www.theguardian.com/society/2024/mar/17/nhs-ombudsman-warns-hospitals-cynically-burying-evidence-poor-care [downloaded 18 March 2024]

5.3.2 Despite the semi-autonomous structure, the NHS is perceived as more than a "*brand*". It was created to be a national service providing equitably distributed healthcare throughout the country with the overarching objective of ensuring that everyone could receive the care and treatment they need free of charge at the point of delivery. Legally the NHS is the emanation of the statutory duty imposed on the Secretary of State to promote a comprehensive health service free of charge.[88] That is the task for which the Secretary of State retains accountability to Parliament, but which is delegated through the statutory structure defined in primary and secondary legislation, which as described above has undergone many changes since 1948.

5.3.3 In addition to the potential tension between local and national leadership there are intra-professional issues: each healthcare profession can have its own culture which risks separating them so that, say, doctors and nurses have different ways of confronting the same issues. This is the result of their separate training, and their differing functions, both of which are necessary and need to be considered. A silo mentality can develop from the differences, real and imagined, between disciplines. Nonetheless, there are overarching cultural principles which they need to share, for example the duty of candour. So it is not surprising that their separate codes of conduct express very similar concepts. However, what is learnt in training, and what results from confrontation with the real world of hospital practice, may be different things, depending on the pre-existing culture of the workplace.

5.3.4 When looking a culture in healthcare, it may be helpful to look at what has changed in professional culture over an extended period. Some of this has been reflected in the common law's development of the duty of care. At risk of over-simplification, until relatively recently healthcare was largely an hierarchical environment led by doctors whose word was law, and in which nurses were subservient to the medical profession in all matters, whether or not they depended on medical skills. There was a separate hierarchy within each profession ranging downwards from the senior consultant and matron respectively. The patient was an entity who was represented by a medical problem that needed treatment, not a person who needed to be regarded holistically. Patients were people to whom things were done, and the judgement as to what was in their interests was for the professionals to decide. This attitude received its legal endorsement in *Bolam v Friern HMC,* [89] which accepted that the common law duty of care was fulfilled by following a recognised professional school of thought. Through the 1990's to the present day this has slowly changed in three respects. Firstly, professional training has emphasised the value of teamwork involving all disciplines, carrying with it the need and obligation to listen to and engage with each other on more equal terms across professional boundaries. Secondly, managerial leadership, prompted by many of the policies already mentioned in this report, has promoted less hierarchical relationships within each profession, at least in theory. Thirdly, and perhaps most importantly, there has been an increase in the importance accorded to consumer rights and human rights, particularly that of autonomy. This has led to greater recognition of the crucial part the

[88] National Health Service Act 2006 section 1

[89] [1957] 1 WLR 583.

patient needs to play in their own treatment and care, whether through the consent process, partnership during treatment itself, or in taking part in the wider policy decision-making in the service. In the law that change has been recognised in cases such as *Montgomery v Lanarkshire Health Board*[90] where the centrality in the consent process of the holistic needs and interests of the patient was stressed. This less hierarchical way of providing healthcare has been discussed since well before the period with which this inquiry is concerned, but some of the more recent scandals may in part be seen as resulting from the older hierarchical attitudes. At the same time, the system's requirements flowing down from the Secretary of State, and what is now NHS England, can impose a pressure at local level to maintain hierarchical styles of leadership and working.

5.3.5 A starting point to considering how a healthy NHS culture ought to be defined is to look at the NHS Constitution. It's first principle is that "*the NHS provides a comprehensive service available to all*" and *"has a duty to each and every individual that it serves and must respect their rights*" but also "*a wider social duty to promote equality through the services it provides and to pay particular attention to groups and sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.*" The second principle is that "*Access to NHS services is based on clinical need, not an individual's ability to pay.*" The fourth principle is that "*the patient will be at the heart of everything the NHS does.*"

5.3.6 This is the task set for the NHS and its staff; the cultural expectations are set out in the NHS Values.

(a) The first NHS Value, *Working together for patients*, sums up a number of features required in the culture of the service:

> *Patients come first in everything we do. We fully involve patients, staff, families, carers, communities and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.*

(b) The second Value *Respect and Dignity* contains important features of a positive culture:

(i) Valuing every patient, carer, staff and family members as individuals;

(ii) Taking what others say seriously;

(iii) Openness and honesty about what can and cannot be done.

(c) Likewise the third Value *Commitment to quality of care*:

(i) Insisting on quality;

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[90] [2015] UKSC 11

(ii) Striving to get the basics right, such as safety, effectiveness and patient experience every time;

(iii) Welcoming feedback from all and using it for improvement.

(d) Finally the fourth value *Compassion* includes the expectation of finding time for patients, families and carers, but also colleagues.

5.3.7 If these values are compared with those of the three organisations quoted above, they are certainly consistent with each other, but it might be asked what is added by the different phrasing. For any organisation to be successful it is obviously beneficial for the staff to feel they are part of something of which they can be proud. If the mission of their organisation is of necessity the same as the national mission of the NHS, it would surely make sense if the values were expressed in the same way supported by a shared understanding of that commitment. That is what should make them proud to work for the NHS. What should make them proud to be employed by a particular frontline organisation is how they go about contributing to the national mission. In other words it is the local strategy and its implementation – how those values are brought to life locally - which allow them to distinguish their organisation from others.

5.3.8 Michael West [see above], said,[91] shortly after the Mid-Staffordshire and Berwick reports, that

> *Positivity, compassion, respect, dignity, engagement and high-quality care are key to creating the cultures we need in the NHS. And, just as importantly, we must deal decisively, consistently and quickly with behaviours inconsistent with these values, regardless of the seniority of people exhibiting them.*

5.3.9 Part of what we talk of as a "*healthy*" culture in the context of healthcare provision is what is often referred to as a "*safety*" culture. An academic authority on patient safety has opined[92] that:

> *If our challenge is to change the culture, as so many commentators urge, then we need to understand what safety culture is, or at the very least decide what aspects to highlight, and bring as much precision to the definition as can be mustered.*

5.3.10 My report referred to various definitions of a safety culture,[93] but it is not sufficient for culture to be "*safe*". It also has to be caring and compassionate. A safe clinical outcome can theoretically be produced by brutal treatment, and I set out some of the components of caring and compassion required.[94] Various other names have been offered for the

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[91] West, *Collective leadership: fundamental to creating the cultures we need in the NHS*, 21 May 2014 King's Fund https://www.kingsfund.org.uk/insight-and-analysis/blogs/collective-leadership-creating-cultures-we-need-nhs [accessed 13 March 2024]

[92] See Mid Staffordshire Public Inquiry report chapter 20 §20.4 quoting *Vincent, C, Patient Safety* (2nd edition, 2010), BMJ Books, p271

[93] Mid Staffordshire Public Inquiry report chapter 20 §20.7-20.11

[94] Ibid §20.12

required culture, including a "*just*" culture,[95] a "*just and learning culture*",[96] a "*no blame*", "*fair no blame*" or "*open and fair*" culture. One writer at least has warned of the need for a shared understanding of what these terms mean, in an article giving a useful summary of the use of the term "*just culture*":[97]

> *The phrase 'just culture' is one of those phrases that can mean whatever someone wants it to mean. This can be a useful trait because it engages debate over meaning and people can take personal ownership of the concept when they ascribe a meaning to it. However, there is now a need to have more central direction from Government in developing the concept.*

5.3.11 An insightful paper by Tasker, Jones and Brake[98] - which I would commend to the Inquiry for its real-life glimpse of the cultural understanding and experience of an albeit limited sample of professionals - pointed out that the term "*safety culture*" emanated from work by James Reason[99] who argued that a safety culture had four components: Just Culture, Reporting Culture, Learning Culture, and Flexible Culture. They observe that despite the focus on these terms there is a risk of generating confusion as to what is meant, even though that may be beneficial if it provokes discussion among their interviewees. While there was universal approval of many of the traits of a "*just culture*" few were actually familiar with the concept, and it was thought that the multiplicity of definitions in circulation was a factor in this. The authors ventured that trainee doctors' apparent lack of confidence in investigatory processes may be caused by this unfamiliarity and a lack of transparency.

5.3.12 The authors used a list of factors in their research interviews to distinguish between a "*just*" culture and a "*blame*" culture and I reproduce it here, as it is a useful summary of many of what I would regard as the significant factors in "*healthy*" and "*unhealthy*" cultures:

Table 2 Traits of a Just Culture

Positive traits (Just Culture)		Negative traits (Blame Culture)
Professional atmosphere	Open, trusting, supportive.	Fear, cautiousness, 'club culture'.

[95] See DH, *Improving Safety and Organisational Performance through a Just* Culture, https://www.gov.uk/government/publications/a-just-culture-improving-safety-and-organisational-performance [downloaded 13 March 2024] ; NHSE, *A just culture guide*, (poster) 2019 https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf [accessed 13 March 2024]

[96] NHS Resolution, *Just and learning charter*, 25 Aril 2023 https://resolution.nhs.uk/resources/just-and-learning-culture-charter/ [downloaded 13 March 2024]

[97] Tingle, *Developing a just culture in the NHS*, 22 April 2021 BJN vol 30 issue 8 https://www.britishjournalofnursing.com/content/patient-safety/developing-a-just-culture-in-the-nhs [downloaded 13 March 2024]

[98] Tasker, Jones and Brake, How effectively has a Just Culture been adopted? A qualitative study to analyse the attitudes and behaviours of clinicians and managers to clinical incident management within an NHS Hospital Trust and identify enablers and barriers to achieving a Just Culture 2023 BMJ Open Quality 2023:12:e002049 https://bmjopenquality.bmj.com/content/bmjqir/12/1/e002049.full.pdf [downloaded 13 March 2024]

[99] Reason J. *Managing the risks of organizational accidents.* Routledge, 2016.

Table 2 Traits of a Just Culture

Positive traits (Just Culture)		Negative traits (Blame Culture)
Attitude to mistakes	Acceptance that mistakes will be made, systems in place to guard against human error.	Shame, embarrassment.
Attitude to reporting mistakes	Tolerance of human error, staff encouraged or rewarded to report mistakes.	Expectation of infallibility.
Focus of investigations	Organisational factors, improvement.	Individual culpability.
Support provided during investigation	Staff believe they will be supported by seniors. Staff expect to be viewed as a professional who behaved with no malicious intent.	Staff do not believe they will be supported by seniors. Staff expect to be viewed with suspicion and have their capability questioned.
Outcomes of investigation	Identify contributing factors. Organisational factors will be addressed and communicated. May be recommendations for further training.	Individual innocence or guilt. No consideration or communication of organisational factors.
Treatment of blame	Recognises that majority of human errors will be mistakes and blame is not appropriate. Recognises unacceptable behaviour such as deliberate action and gross negligence.	Blame culture—blame is prevalent and individual culpability will be suspected until evidence suggests otherwise. No-blame culture does not recognise and address unacceptable behaviour.

5.3.13 All the traits listed, positive and negative, are capable of being detected by direct observation, talking to staff and service users, surveys and outcome measures. Among the authors' recommendations for the Trust where they conducted this limited research was that it should discuss with their staff a more precise definition of what a "*just culture*" means to them.

5.3.14 Given this background I approach the question with due diffidence, conscious of the risk of adding to confusion rather than reducing it. So what does a "*healthy*" culture look like in an NHS context? One answer I offer is to re-read the section of my Inquiry report

"*What would a common culture look like?*".[100] While this specifically addressed the culture of an older persons ward, it could be applied to any hospital context. However in order to achieve the behaviours described it might be helpful to set out here what I regard as the ingredients needed:

(a) Positive values are adopted and integrated into the working life of all staff

(i) The organisation, its leadership and its staff always put their service users first and understand that is their purpose. This will require everyone to be "*in it together*"

(ii) Staff will be willing to do what is necessary for service users even when this means going beyond the normal limits of their duties

(iii) All leaders and staff will accept this responsibility whether or not it is part of their job description: maintenance men will work to help service users, nurses will give an alert about safety issues, directors will pick up litter.

(iv) Staff will demonstrate compassion and empathy towards all service users and each other, whatever the pressures. They will instinctively want to help people they meet at work and be conscious that even momentary acts of kindness can make an exponential improvement to a user's experience of their care.

(b) Staff well-being is seen as a priority obligation by the organisation, and staff recognise the same obligation to each other

(i) There is a shared understanding that staff well-being is crucial to fulfilling the organisation's purpose and is seen as a priority so that:

(ii) The organisation will ensure that working conditions meet staff needs. It is astonishing how often basic requirements such as provision of water, breakout/rest space, decent food available during night shifts etc are said to be absent.

(iii) Short staffing may be inevitable, but insisting on working through unsafe conditions is not. Avoidance of staffing working beyond their physical and emotional endurance is essential.

(iv) Hiring temporary staff to address staff shortage raises issues about learning from incidents which need careful management. Recent analysis suggests that temporary staff is are not always able to report incidents and are often not engaged in investigations of patient safety incidents.[101]

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[100] Mid Staffordshire NHS Foundation Trust Public Inquiry Report vol 3 chapter 20 §§ 20.101- et seq.

[101] HSSIB, *Investigation Report: Temporary staff – involvement in patient safety investigations*, 14 March 2024. https://www.hssib.org.uk/patient-safety-investigations/workforce-and-patient-safety/ [downloaded 8 April 2024]

(v) Measures to support emotional health such as Schwartz rounds will be in place.

(vi) Occupational health is seen as a service for the benefit of staff, rather than a performance management tool for the employer

(c) Involvement of staff of all disciplines and grade and recognition of the value they contribute are constants in the way the organisation is run

(i) Staff are fully involved in the making of and implementing policies and procedures to fulfil the organisation's obligations and goals.

(ii) Leaders will want to learn from them what works best at the frontline and be wary of introducing change which is not "*owned*" by the staff.

(iii) Staff must be explicitly valued for their commitment and excellence, and supported when their morale is subject to pressures and poor outcomes. It is notable that many CQC inspection reports which are critical of safety and leadership praise the staff for their commitment and compassion. Organisations aspiring to a "*healthy*" culture will recognise and address the moral and emotional conflict suffered by staff in those circumstances.

(d) Freedom to speak up is part of normal working life

(i) Staff will feel free to raise concerns as part of business as usual and will be supported and celebrated when they do so. There will be multiple ways of them doing this. Dealing with issues they raise, and being seen to do so, is more important than insisting on a prescribed process, however convenient that may seem:

(ii) All staff will work and behave by the Freedom to Speak Up principles;

(iii) FTSU Guardians will feel safe and supported in their work at all leadership levels;

(iv) Conduct which obstructs speaking up whether or not intentional is not tolerated;

(v) Leaders will be exemplars of openness about matters of concern and of how they will be dealt with.

(e) Oppressive behaviour is never acceptable or tolerated

(i) Bullying, harassment, discrimination and other forms of oppressive behaviour will not be tolerated under any circumstances; leaders and staff will be united in calling it out: and if it is not rapidly corrected it should be considered a very serious matter.

(ii) Leaders need to have the capacity of understanding and correcting systemic issues which may explain, but not excuse such conduct.

(iii) Leaders will measure the incidence of oppressive behaviour and see a reluctance to report it as indicating a high risk of cultural deterioration.

(f) Poor patient outcomes are never accepted and always used for learning

(i) While undesired and unexpected outcomes will happen, even when described as "*never events*". They should not be accepted passively, but always seen as opportunities for improvement.

(ii) Leaders and staff will seek to establish objectively what happened, the reasons for the outcome and the learning to be obtained.

(iii) There will be an available resource for independent and objective investigation by trained investigators which is deployed proportionately with the gravity of an incident for patients or the public interest.

(iv) All staff will participate and cooperate in such investigations.

(v) Acceptance of responsibility to commit to learning and improvement should be supported and insight insisted on and evidenced.

(vi) Only in rare cases will it be appropriate to take disciplinary action for error.;

(vii) All staff will feel under a duty even in relation to apparently unavoidable adverse outcomes to work towards reducing their incidence.

(viii) Being candid with service users when things go wrong should be natural and immediate, and the appropriate support to facilitate this will be available.

(g) Measurement of culture is considered important

It is possible to measure cultural health and leaders must commit to doing so and sharing the results and intended action and analysis with staff and the public.

5.4 Neonatal units

5.4.1 So far I have considered what I would regard to be the essential features of a "*healthy*" culture generally in NHS organisations, particularly acute providers. With regard to neonatal units I suggest that the same principles apply. However the application of the culture perhaps faces greater stress and challenge because of the nature of the work of such units. By definition such units are serving the most vulnerable people in our society, who cannot speak for themselves, and are entirely dependent on others for their very existence, on a minute-by-minute basis. Staff are required not only to address the needs of such patients, but also of their families and on a regular basis have to cope with

unfolding tragedy. In recent years there has been a greater focus on the issue of these units and how they should be supported.

5.4.2 In 2015 the perceived requirements for safe running and staffing of neonatal units could be derived from the DH *Toolkit for high quality neonatal services* (2009), NICE's quality standard QS4, the BAPM *Service Standards for hospital provided neonatal care* (2010), and BAPM *Optimal Arrangements for neonatal intensive care units in the UK including guidance on their medical staffing: a framework for practice* (2014).[102]

5.4.3 In 2015 a report[103] suggested that two thirds of neonatal units did not have sufficient specialist nursing staffing to meet the national guidelines, and that 2,140 nurses were needed. It said:

> *Our findings reveal a system in trouble, with a significant shortage of nurses, doctors and other professionals that are needed to deliver safe and high-quality care to premature and sick babies. The dedicated, hard-working staff at neonatal units across the country are being stretched to breaking point – putting babies' safety and survival at risk and impacting their long-term development.*

5.4.4 It found that 70% of neonatal intensive care units were consistently caring for many more babies than was considered safe and 855 babies were transferred between hospitals due to a shortage of cots rather than medical need.

5.4.5 The effects on the staff are easy to imagine and are confirmed by studies. A 2008 paper suggested that neonatal intensive care nurses could experience high levels of psychological stress,[104] what Michael West has called "*moral distress*".[105]

5.4.6 In the same year the Department of Health announced a target to reduce stillbirths, neonatal and maternal deaths by 50% by 2030, and a "*care bundle*", *Saving Babies Lives* was introduced.

5.4.7 According to NHS England in 2016-17 there were 2263 fewer nurses than required to meet the national standard.[106]

5.4.8 In 2017 NHSE England published the results of its National Maternity Review, *Better Births*, a five year plan to improve maternity care. This recognised that difficulties in medical and nurse staffing numbers in neonatal units had been identified and that a

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[102] I have relied for this passage on the summary in the 2018 NQB report [reference below] and have not accessed the original reports

[103] Cleland, *Hanging in the Balance* 2015 BLISS https://s3.eu-west-2.amazonaws.com/sr-bliss/images/Bliss-baby-report-2015-Hanging-in-the-balance-England.pdf [downloaded 15 March 2024]

[104] Braithwaite M, *Nurse Burnout and Stress in the NICU*, December 2008, Advances in Neonatal Care 8(6):p 343-347, December 2008, https://journals.lww.com/advancesinneonatalcare/Abstract/2008/12000/Nurse_Burnout_and_Stress_in_the_NICU.16.aspx [abstract only seen]

[105] Health and Social Care Committee, *Workforce burnout and resilience in the NHS and social care*, 18 May 2021 HC 22, page 8 §12 https://committees.parliament.uk/publications/6158/documents/68766/default/ [downloaded 15 March 2024]

[106] NHS England, *Implementing the Recommendations of the Neonatal Care Transformation Review,* 2020 page 13 https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf [downloaded 15 March 2024]

neonatal review was required.[107] As a result NHSE commissioned a Neonatal Critical Care Review.

5.4.9 In 2018 the National Quality Board published an "improvement resource" for neonatal care.[108] This recommended that Boards "must ensure a strategic multi-disciplinary staffing review at least annually, with a mid-year review to provide assurance that neonatal services were safe and sustainable". Further skill mix needed to be reviewed regularly to ensure staff were most suitable in the correct roles, and available in sufficient numbers. Areas of concern highlighted by parents, families, or staff should be carefully scrutinised and appropriate actions taken to address them. The report was clear that:

> *Safe care must remain paramount and, irrespective of policy drivers, organisations have a responsibility and remain accountable for ensuring that babies and families receive high quality care in the right place at the right time, delivered by staff equipped to provide safe, dignified and compassionate care. Managers with a professional registration must also always act in accordance with their professional accountability for the provision of safe care under their Code of Conduct.*

5.4.10 While the language of this report may have been influenced by the arrival of a means of assessing performance called *Getting It Right First Time* (GIRFT), there is little in this passage which would not have been regarded as an obligation in 2015. What may have changed was a strengthened concern to reduce mortality. Among the detailed guidance on the nurse manager's role in recruitment and retention is a requirement that the nurse manager should:[109]

> *Also understand what factors are affecting recruitment and retention of staff, and ensure all staff are given appropriate career development and have job satisfaction. Areas which will require attention, while ensuring the effective and safe staffing of the unit, include*
>
> - Personal circumstances
> - *Individual aspirations*
> - *Shift patterns*
> - *Education and training opportunities*
> - *Flexible working conditions*

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[107] National Maternity Review, *Better Births - Improving outcomes of maternity services in England*. Page 64 §4.56 et seq, 22 February 2016. https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/ [downloaded 15 March 2024]

[108] NQB, *Safe, sustainable and productive staffing - An improvement resource for neonatal care*, June 2018, https://www.england.nhs.uk/wp-content/uploads/2021/04/safe-staffing-neonatal.pdf [downloaded 15 March 2024]

[109] Ibid page 30 §3.3

- *Individual workloads*
- *Family environments*
- *Ward/organisational culture*
- *Professional leadership*
- *Team dynamics*
- *Leadership and culture*

5.4.11 This was clearly a call for managers at this level to be cultural leaders, and to consider the individual circumstances of their staff, and to support their well-being. The guidance also reminds[110] organisations that:

> *Staff should be encouraged to report any occasions where a less than optimal level of staffing is likely to have or has resulted in harm to a patient (Care Quality Commission – CQC 2015).*
>
> *All staff members should be aware of their professional duty to put the interests of their patients first and must act to protect them if they consider they may be at risk (General Medical Council 2012, NMC 2015a). This includes incident reporting when staffing levels are less than optimal to ensure a ward-to-board approach.*

5.4.12 In 2019 NHS England published its response to the review of neonatal critical care. It was noted that some of the shortage was caused by more stringent entry requirements, but there were not only high vacancy rates but 25 % of the nursing workforce were aged over 50 and likely to retire within 10 years.[111]

5.4.13 In 2020 The Royal College of Paediatrics and Child Health conducted a snapshot survey of the service[112]. It found significant staffing deficiencies compared with other services. To quote the summary of the report:

> *This snapshot, undertaken prior to the COVID-19 pandemic, highlights ongoing problems with staffing within both the medical, nursing and Allied Health Professional workforce in neonatology. Medical staffing demonstrates low levels of compliance with BAPM staffing standards as well as a 10% gap in rotas, with half of these gaps filled by locums. Medical rota gaps occurred predominately in daytime shifts. Although this could be a chance finding, it is consistent across both days of the snapshot and suggests that staffing on night-time rotas (which is significantly lower than daytime rotas) is prioritised*

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[110] Ibid page 35-36 §5.2

[111] 2019 NHSE implementing the review report [see above for reference] page 13

[112] RCPCH/GIRFT, *A snapshot of neonatal services and workforce in the UK*, September 2020 https://www.rcpch.ac.uk/sites/default/files/2020-09/a_snapshot_of_neonatal_services_and_workforce_in_the_uk_2.4.pdf [downloaded 15 March 2024]

> *to support safe care, which may come at the expense of weekday medical training opportunities. Neonatal nurse staffing demonstrated a 15% gap in rotas and low compliance with BAPM nursing standards, which was most marked in NICUs.*

5.4.14 Of particular significance was the finding that only 49%, 45% and 29% respectively of neonatal and local intensive, and special care, units were compliant with national medical staffing guidelines on weekday nights. Only 60% of neonatal intensive care units, and 86% local neonatal units met national nurse staffing standard overall. However almost all staff, medical and nursing thought that patients were safe all or most of the time.

5.4.15 In 2023 NHS England published a three-year plan for maternity and neonatal services,[113] designed to bring about improvements following the various reports by Donna Ockenden and Dr Kirkup, and engagement with affected families and their representative organisations. The plan accepted that maternity and neonatal services did not have the staff numbers in any of the professions concerned which were needed in this area,[114] thus placing them under increased pressure to provide the desired standard of service.

5.4.16 It emphasised that:[115]

> *It is everyone's responsibility to provide or support high quality care. That includes a responsibility at each level of the NHS to understand the quality of care and identify, address, and escalate concerns.*

5.4.17 The most consistent priority among those using and providing services was safe care:

> *"Safe, compassionate care, which allows you the confidence to speak up and be listened to if something is not right." (Service user)*
>
> *"We need to take action and make a pledge to improve the safety of every maternity service in England." (Leader)*

5.4.18 This involves listening to and working with women and families with compassion, and growing and retaining and supporting the workforce:[116]

> *"You told us that there needs to be a positive culture and leadership in services. Staff need to be free to speak up, in an environment that learns from experiences and incidents and does so with compassion."*
>
> *"Listening, learning and facing up to failings." (Stakeholder")*

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[113] NHS England, *Three year delivery plan for maternity and neonatal services*, 20 March 2023 https://www.england.nhs.uk/long-read/three-year-delivery-plan-for-maternity-and-neonatal-services/ [downloaded 15 March 2024]

[114] Ibid page 16 §2.1

[115] Ibid page 4 §7

[116] Ibid page 6 §15

"Confidence in the care provider, trust, integrity and honesty if mistakes occur." (Leader)

"Leadership training to enable managers to better manage teams and support them." (Workforce member)

"Psychological safety at work and teams that work together with a shared vision and a foundation of kindness." (Stakeholder)

5.4.19 The importance of valuing and retaining the workforce as well as promoting recruitment was recognised.[117] Measures were proposed to improve staff experience, make them feel valued and to have equality of opportunity, and to provide:

a safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination.

5.4.20 The plan also addressed the need to promote a "*safety culture*" and set out actions in the areas of developing, sustaining a "*positive safety culture for everyone*", learning and improving, and support and oversight.[118] An ambition was expressed with regard to the safety culture that:

- *All staff working in and overseeing maternity and neonatal services:*
  - *Are supported to work with professionalism, kindness, compassion, and respect.*
  - *Are psychologically safe to voice their thoughts and are open to constructive challenge.*
  - *Receive constructive appraisals and support with their development.*
  - *Work, learn and train together as a multi-disciplinary team across maternity and neonatal care.*
- Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.
- Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.
- There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to 'how' things are implemented not just 'what'.

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[117] Ibid pages 18-19 §2.10

[118] Ibid pages 24 et seq §3.1 et seq

- *Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.*

- Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy.

- Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief.

5.4.21 The plan referred as supporting material to the Maternity and Neonatal Champions Toolkit,[119] and the NHS national speak up policy.[120]

5.4.22 Reviewing this material in roughly chronological order suggests that the overarching cultural principles understood within the NHS have, throughout the period with which this report is concerned, been broadly consistent with the suggestion I have made above for a "*healthy culture*" and further that those principles have been regarded as applying to neonatal services as much as anywhere else. What, however, has changed over the years has been an increased concern about the standards of care provided and the need to reduce dramatically stillbirths, and neonatal and maternal mortality. This appears to have generated a more detailed set of requirements and recommended methods of cultural change for maternity and neonatal services. However, in answer to the question, what would I suggest as a description of a healthy culture in neonatal services, it would start with my principles set out above, but would explicitly endorse the approach taken in the latest three-year plan. A proviso has to be that the plan us unlikely to be successful unless the issues around the shortage of appropriate skilled staff is solved.

[119] NHS England, *Maternity and Neonatal Safety Champions Toolkit* September 2020 https://www.england.nhs.uk/wp-content/uploads/2021/02/Feb-2021-Maternity-and-Neonatal-Safety-Champions-Toolkit-July-2020.pdf [Accessed 15 March 2024]

[120] NHS England, *The national speak up policy*, 23 June 2022, https://www.england.nhs.uk/publication/the-national-speak-up-policy/ [downloaded 15 March 2024]

5.5 *How has this definition changed over time and why? Please focus in particular on the period 2015 onwards and the present day*.

While, as can be seen, I, and I suspect many others, struggle to put the concept of the appropriate culture into consistent language, I do not think the underlying understanding has changed at all. I have described the developments in it in the previous section, I hope sufficiently.

5.6 *How do you identify an unhealthy culture in the NHS and what source(s) of information would you use?*

5.6.1 An easy answer would be to suggest that an unhealthy culture can be detected when the opposite of its requirements is evident. A more helpful one might to be point to traits such as those in the Tasker article cited above which are in the main observable through physical inspection, interaction with service users, staff and leaders, and interrogating data about outcomes for patients, rather than processes. An unfortunate example of the identification of an unhealthy culture can be found in the recent reported interview with the Parliamentary and Health Service Ombudsman[121] in which he had clearly come to the bleak conclusion that the system as a whole was blighted by unhealthy culture. He cited:

(a) Trusts "*cynically burying evidence about poor care*";

(b) Denying families the truth about their loved ones;

(c) Inaction by politicians, NHS national leaders and Trust Boards to stop this;

(d) Victimisation of staff who raise concerns;

(e) A focus on "*reputation management*";

(f) Failure to enforce the duty of candour;

(g) Tolerance of avoidable deaths and harm;

(h) A failure of leaders to "*set the tone*", and tackle "*disgraceful*" behaviour.

5.6.2 There are a number of methods by which at least the risk of an unhealthy culture can be identified, for example:

(a) NHS Staff survey at national or local level as relevant;

(b) CQC inspection reports;

[121] Campbell, *NHS ombudsman warns hospitals are cynically burying evidence of poor care*, 17 March 2024, The Guardian https://www.theguardian.com/society/2024/mar/17/nhs-ombudsman-warns-hospitals-cynically-burying-evidence-poor-care [downloaded 18 March 2024]

(c) Staff/service user feedback;

(d) Invited review reports

(e) GMC trainee survey

(f) Mortality statistics and other outcome measures

(g) Complaints

(h) Incident reports.

(i) Employment tribunal reports

(j) Reports of inquests.

5.7 *Are there accepted practices for improving an unhealthy culture in the NHS?*

There are any number of "*tools*", methodologies and papers on how to improve culture, some of which have been referred to above. Indeed one of the challenges facing, say, a newly appointed CEO of a troubled organisation may be choosing their methods from this abundance. What follows are but some of the examples available:

(a) As long ago as 2005 the NHS Institute for Innovation and Improvement published a series of improvement leaders' guides, one of which one on improving culture.[122]

(b) In 2015 the King's Fund included a webpage[123] on its site bringing together various resources on Inspiring vision and values, goals and performance, support and compassion, learning and innovation, effective teamwork, and collective leadership. At the time, and probably now, King's Fund organised courses, conferences, and seminars for leaders on these themes. For example their annual leadership and workforce summit. In 2017 they published a guide on embedding a culture of quality improvement.[124]

(c) Since 2016 NHS England/Improvement has provided a Culture and Leadership programme.[125] It has recently been externally evaluated.[126]

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[122] NHSIII, *Improvement Leaders Guide: Building and nurturing an improvement culture* 2006, https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ILG-3.3-Building-and-Nurturing-an-Improvement-Culture.pdf [downloaded 18 March 2024]

[123] https://www.kingsfund.org.uk/insight-and-analysis/projects/improving-nhs-culture [accessed 18 March 2024]

[124] https://assets.kingsfund.org.uk/f/256914/x/9fa0215ed8/embedding_culture_quality_improvement_2017.pdf [accessed 18 March 2024]

[125] https://www.england.nhs.uk/culture/ [accessed 18 March 2024]

[126] Kilbane et al, *Formative Evaluation of NHS England and NHS Improvement's Culture and Leadership Programme*, April 2020, University of Manchester Alliance Manchester Business School, University of Birmingham https://www.england.nhs.uk/wp-content/uploads/2021/08/CLP-Evaluation-Executive-Summary-300420-2.0.pdf [downloaded 18 March 2020]

(d) In 2019 NHD Improvement published a "*Just Culture Guide*",[127] designed to assist in addressing concerns after an incident about the action of an individual.

(e) NHS Providers has a webpage bringing together a large number of resources aimed at assisting the development of an improvement culture.[128]

(f) NHS England has collected together on a webpage resource to assist new senior leaders in developing their leadership style and creating an appropriate culture.[129]

6. Safeguarding

6.1 *What specific attention or separate consideration is safeguarding for neo-nates or babies in hospital given within the policies and practice of patient safety? Should closer attention be given to policies for safeguarding and the protection of babies in hospital?*

In the time available I cannot claim to have accessed, or referred in what follows to every piece of policy or practice, but what follows may give a sufficient overview for the inquiry's purposes. I should make it clear that child safeguarding as such is not part of my area of expertise.

6.2 *What specific attention or separate consideration is safeguarding for neo-nates or babies in hospital given within the policies and practice of patient safety?*

6.2.1 The Government issues statutory guidance on safeguarding children. In March 2015 earlier 2013 guidance was replaced by *Working Together to Safeguard Children*,[130] This guidance referred to the particular care required in the assessment (by the local authority) of children who were thought to need assessment and were in hospital.[131] NHS Trusts and Foundation Trusts were among bodies listed as statutory partners whose representative must be included on the Local Safeguarding Children's Board (LSCB).

6.2.2 Under the Local Safeguarding Children Boards Regulations 2006, and section 14(2) of the Children Act 2004 the LSCB was responsible for collecting and analysing information about *each* (i.e. not limited to sudden or unexpected) death of a child normally resident in the LSCB's area to identify those requiring a statutory review, matters of concern affecting the safety and welfare of children in the area and any wider public health or

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[127] https://www.england.nhs.uk/patient-safety/patient-safety-culture/a-just-culture-guide/ [accessed 18 March 2024]

[128] https://nhsproviders.org/deliver-and-improve/understanding/improvement-cultures-behaviours-and-skills [accessed 18 March 2024]

[129] https://senioronboarding.leadershipacademy.nhs.uk [accessed 18 March 2024]

[130] March 2015, https://www.nwleics.gov.uk/files/documents/working_together_2015/Working_Together_to_Safeguard_Children%202015.pdf [downloaded 2024]

[131] Ibid page 22 §38

safety concerns arising from a particular death or a patten of deaths in the area. There was to be a Child Death Overview Panel. The Government guidance makes it clear that the purpose of child death reviews is to help prevent further such child deaths, not to allocate blame.[132] From the flow chart in the guidance the review by the panel is a paper based one. By way of comment, the requirement that the review is required by the local authority for area in which the child was resident could mean that the review is taken remotely from the area in which the hospital was situated.

6.2.3 A section of the guidance dealt with the required action in the case of an unexpected death of a child. "*Unexpected death*" was defined as:[133]

> *an unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.*

6.2.4 Where there was uncertainty the designated paediatrician responsible for unexpected deaths in childhood was to be consulted and if doubt remained, the process for an unexpected death should be followed.[134] In the case of an unexpected death of a child the consultant clinician in a hospital setting should inform the local designated paediatrician at the same time as informing the coroner and the police and should initiate an immediate information and planning discussion between lead agencies to decide what should happen next and who will do it. The guidance outlines [135] the responsibilities of all professional and agencies involved. Child deaths were required to be notified to CQC and/or NHS England. However while this guidance clearly covers the case of unexpected deaths in hospital, it makes no specific provision for babies or neonates. The principle concern which these processes were intended to address are more likely to have been suspicion of abuse or harm caused outside the hospital or, if within it, by an external party, rather than harm caused error or deliberate act on the part of hospital staff.

6.2.5 Under amendments made by the Children and Social Work Act 2016 to section 10 of the Children Act 2004 duties were placed on the police, integrated care boards and local authorities to make arrangements to work together and with other partners to safeguard and promote the welfare of all children in their area.[136] Safeguarding includes protection of children from maltreatment, whether in or outside the home. Under section 11, NHS trusts and foundation trusts are placed under a duty to make arrangements to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children, and must have regard to any statutory guidance. The

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[132] Ibid page 81 §1

[133] Ibid page 85 §12

[134] Ibid page 85 §13

[135] Ibid page 85-86 §15

[136] See 2023 guidance referred to below

Government has also published a summary of the statutory framework of legislation relevant to safeguarding.[137]

6.2.6 The latest edition of the Government's statutory guidance was published in December 2023.[138] This requires local authorities to develop and maintain a local protocol which should reflect the needs of groups, including children in hospital.[139] Paragraph 34 requires all practitioners in all agencies to notify the child death review partners of any death of which they become aware. Paragraph 395 it requires that, whenever a child dies, practitioners should work together in responding to the death "*in a thorough, sensitive and supportive manner*". The aims of the response are to:

(a) *establish, as far as is possible, the cause of the child's death;*

(b) *identify any modifiable or contributory factors;*

(c) *provide ongoing support to the family;*

(d) *learn lessons in order to reduce the risk of future child deaths and promote the health, safety, and wellbeing of other children;*

(e) *ensure that all statutory obligations are met.*

6.2.7 A joint agency approach is required if a child's death:

(a) *is or could be due to external causes;*

(b) *is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy or childhood) occurs in custody, or where the child was detained under the Mental Health Act;*

(c) *occurs where the initial circumstances raise any suspicions that the death may not have been natural;*

(d) *occurs in the case of a stillbirth where no healthcare professional was in attendance.*

6.2.8 Paragraph 399 states that if the results of any investigation suggest evidence of abuse or neglect as a possible cause of death, all practitioners should inform relevant safeguarding partners and the panel immediately.

6.2.9 Thus the guidance includes but does not explicitly refer to deaths in a neonatal or baby unit.

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[137] HM Government, *Working Together to Safeguard Children – Statutory framework: legislation relevant to safeguarding and promoting the welfare of children*, December 2023, https://assets.publishing.service.gov.uk/media/65cb4349a7ded0000c79e4e1/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf [viewed 16 May 2024]

[138] DH, *Working Together to Safeguard Children 2023: A guide to multi-agency working to help, protect and promote the welfare of children*, December 2023 https://assets.publishing.service.gov.uk/media/65cb4349a7ded0000c79e4e1/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf [downloaded 15 March 2024]

[139] Ibid page 84 §142

6.2.10 NHS England issues guidance on safeguarding directed. They published a safeguarding accountability and assurance framework in March 2013, and this was updated in August 2019.[140] The 2019 requirements included the following:

(a) It was the responsibility of every NHS body and every professional working within the NHS to ensure that the principles and duties of safeguarding children [and adults] *"are holistically, consistently and conscientiously applied"*;

(b) Every NHS body should ensure that there is sufficient capacity to fulfil their statutory duties;

(c) Safeguarding arrangements should be regularly reviewed;

(d) While checks should be made with the Disclosure and Barring Service on all people entering the NHS workforce, *"it is only a snapshot of intelligence known at the time of the check. A DBS check does not guarantee that the employee does not pose a risk.";*

(e) Attention was drawn to the duty of candour in relation to safeguarding incidents;

(f) Information must be shared to protect children and to prevent or detect crime;

(g) Where it is considered a member of staff poses a risk to children or might have committed a criminal offence against one or more children information must be shared with the Local Authority Designated Officer;

(h) Safe recruitment practices and arrangements for dealing with allegations against staff;

(i) An executive lead for safeguarding children;

(j) A suite of safeguarding policies and procedures;

(k) Effective safeguarding supervision arrangements for staff;

(l) *"developing an organisational culture where all staff are aware of their responsibilities for safeguarding and information sharing";*

(m) *"developing and promoting a learning culture to ensure continuous improvement".*

I have no reason to believe that the 2013 edition did not contain similar requirements.

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[140] NHS England, NHS Improvement, *Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework*, March 2013, PAR 000392 https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-children-young-people-adults-at-risk-saaf.pdf [downloaded 16 May 2024]. I have been unable so far to access the 2013 edition

6.2.11 The latest version of its accountability framework is the third edition dated June 2023.[141] While it is an update, it appears to contain all the requirements for provider trusts listed above

6.2.12 NHS England maintains a web page on safeguarding directed at general practice, last updated in March 2024 [142] While applying to all categories of vulnerable persons, it includes specific reference to vulnerable children, defined as those "*in need of special care and support or protection because of age, disability, risk of abuse or neglect.*" Detailed information on information sharing is offered. There is an NHS safeguarding app giving users access to up-to-date legislation and guidance. NHS England resources the National Network of Designated Healthcare Professionals for Children, which gives a voice to the doctors and nurses who work in children's safeguarding, looked after children and child death overview panels.

6.2.13 More specific to babies is the *Child protection Information System* which assists information sharing between local authorities and health, identifying and safeguarding unborn babies and children who are subject to a local authority Child Protection Plan when attending unscheduled healthcare settings, such as A&E, in England. They say[143] they are working to add scheduled care settings such as paediatric and maternity wards to the system. The service has been "*live*" since 2014. However, its focus on children already identified as vulnerable in the community is perhaps of limited assistance in relation to protecting other children in hospital from the risks of abuse in that setting.

6.2.14 In December 2020 NHS England published *Implementing a revised perinatal quality surveillance model*. It observed that insight gathered suggested that

> *… trust board oversight of perinatal clinical quality in provider organisations remains variable. Reasons for this include*
>
> - *perinatal clinical quality is not always reviewed regularly and methodically using a consistent set of data and information*
> - *variable understanding of maternity services on the part of board members*
> - *variable effectiveness in different models of safety champion*
> - *challenges reparenting perinatal clinical quality in a context of competing priorities.*

6.2.15 Six requirements were set out to remedy these issues. The document described the expectation that every Trust board would have a safety champion with a remit to bring together insight and strategic oversight and leadership on perinatal safety and proposed

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[141] NHS England, *Safeguarding children, young people and adults at risk in the NHS, Safeguarding accountability and assurance framework*, 21 July 2022, https://www.england.nhs.uk/publication/safeguarding-children-young-people-and-adults-at-risk-in-the-nhs-safeguarding-accountability-and-assurance-framework/ [downloaded 16 May 2024]

[142] NHS England, *Safeguarding*, Version 1.3 June 2023 updated 14 March 2024 https://www.england.nhs.uk/long-read/safeguarding/ [accessed 15 March 2024]

[143] https://digital.nhs.uk/services/child-protection-information-sharing-service [accessed 15 March 2024]

measures to strength board oversight in this area, as well as improving the focus on this topic of external governance structures. Emphasising that responsibility lay primarily at provider level, with the support of safety champions and the trust board, it suggested that a range of intelligence sources should be drawn together to assure the board that quality was not deteriorating. Non-exhaustive examples were given of intelligence which should warrant further enquiry:[144]

(a) *outlier status for perinatal and/or neonatal mortality;*

(b) *concerns identified through the trust, board, LMS or regional dashboard;*

(c) *thematic reviews identifying poor care as a contributory factor to outcomes;*

(d) *service user concerns, including themes from the CQC maternity survey;*

(e) *concerns raised by HSIB, NHS Resolution, through the Invited Review process, NMC, GMC and/or the deanery;*

(f) *concerns raised by CQC;*

(g) *themes from trainee or staff surveys;*

(h) *triangulated data which suggests a need for further enquiry.*

A number of actions, and interventions by external NHS bodies were suggested in the event of concerns suggesting a need for further inquiry.

6.2.16 NHS England has a *Safeguarding accountability and assurance framework* currently in version 3 dated 21 July 2022.[145] Like the earlier 2013 iteration,[146] this addresses governance structures and does not appear to contain any specific provision for neonates or babies in hospital as opposed to those for children in general. However, relevant this inquiry, the framework does make provision[147] for allegations against staff where it is considered a member of staff poses a risk to children, albeit that this is under a heading of "*child abuse*".

6.2.17 CQC states[148] that it helps safeguard "*people*" [their term for all who use care services, including children] by:

(a) Using information, particularly that about abuse, harm and neglect, to look at the risks to people using services;

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[144] NHSE, *Implementing a revised perinatal quality surveillance model*, December 2020 PA 363 https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf [downloaded 15 March 2024]

[145] https://www.england.nhs.uk/wp-content/uploads/2015/07/B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf [accessed 15 March 2024]

[146] NHS Commissioning Board, *Safeguarding Vulnerable People in the Reformed NHS, Accountability and Assurance Framework*, 21 March 2013, https://www.choiceforum.org/docs/safeas.pdf [accessed 15 March 2024]

[147] Ibid page 13 §3.5.6

[148] CQC, *Safeguarding people*, 16 November 2022, https://www.cqc.org.uk/what-we-do/how-we-do-our-job/safeguarding-people [accessed 15 March 2024]

(b) Referring concerns to local authorities and the police for investigation;

(c) Inspections to talk to pole to help identify safeguarding concerns;

(d) Taking action if services do not have appropriate safeguarding arrangements;

(e) Publishing their findings on safeguarding;

(f) Working with other public authorities;

(g) Taking part in multi-agency safeguarding inspections.

6.2.18 The RCPCH published multi-agency guidelines for care and investigation of sudden expected death in November 2016[149], replacing its earlier 2004 work. While, as the title of the guidance implied, it focused on sudden unexpected deaths, its scope covered *all* unexpected deaths in childhood excluding stillbirths, up to the age of 18, with unexpected deaths in the neonatal period and deaths between the ages of 0 to 24 months being explicitly referred to. The guidance addresses "*unusual clinical situations*" such as death after septic shock has become established; then death can be "*anticipated*", and an investigation may not be required. It also states at paragraph 5 that:

> *When a newborn infant suddenly collapses and dies in a neonatal unit, consideration should be given as to whether a joint agency approach is required. In most situations this would not be appropriate.*

6.2.19 In March 2022 the National Medical Examiner published good practice guidance in relation to child deaths.[150] By this time medical examiners had been widely introduced and a statutory system was in the process of being enacted. This pointed out that all deaths in England and Wales will be independently scrutinised by a medical examiner or a coroner, and that by establishing processes to provide scrutiny after the death of a child bereaved parents would benefit from scrutiny in the same way as other bereaved people. The note recognises that the great majority of child deaths occur in hospital, with 33% being due to perinatal or neonatal events,, and 18% due to external causes, and 4% sudden and unexpected. The role of the medical examiner was not to replace the Child Death Review process previously described, but clearly would be a much closer independent source of scrutiny than would be generally provided by the CDOP.

6.3 *Should closer attention be given to policies for safeguarding and the protection of babies in hospital?*

6.3.1 I believe that the introduction of medical examiners and their roles as described in the guidance quoted above, will give better assurance that appropriate scrutiny of child and baby deaths in hospital has occurred. They will have the advantage over the safeguarding

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[149] RCPath, *sudden unexpected death in infancy and childhood*, 2nd edition November 2016 https://www.rcpath.org/static/874ae50e-c754-4933-995a804e0ef728a4/Sudden-unexpected-death-in-infancy-and-childhood-2e.pdf [downloaded 15 March 2024]

[150] Fletcher, *National Medical Examiner's Good Practice Series No 6 Medical Examiners and child deaths* March 2022, RCPath https://www.rcpath.org/static/7fa7a9d6-ada5-4597-b16f4602c93d3e91/Good-Practice-Series-Child-Deaths.pdf [downloaded 15 March 2024]

review system of being empowered to access the hospital and the relevant units, and to discuss matters with the certifying doctor, and read the medical records. Most importantly they will have direct access to families to elicit any concerns they may have. In theory at least this should reduce the number of erroneous causes of death being certify and improve the quality of decision-making about referrals to the coroner. Together with the coroner, the medical examiner is also likely to be able to discern any potentially concerning patterns of death than might be possible for a more distant agency.

6.3.2 However, it would be fair to comment that much of the focus of safeguarding has understandably been on the need to protect children from abuse by families and third parties away from the hospital setting as opposed to any risk from within, whether from malign actors on the staff, or from unsafe hospital practice. This is in part due to the necessary reaction to scandals such as Baby P, the developing understanding of sudden death syndrome, and the further scandal of wrongful convictions owing to erroneous or misunderstood expert advice. For example in 2021 the Child Safeguarding Practice Panel published a report[151] into non-accidental injury caused to under 1 year-olds by their fathers or other males in a caring role. It observed that in the majority of cases where babies have been killed or injured men have been the perpetrators. It pointed to research suggesting that men are between 2 and 15 times more likely than women to cause such harm.

6.3.3 Unfortunately it can no longer be safely assumed that there is no risk to children from staff. Of course homicide of the sort under consideration at this Inquiry is rare, but, given the likelihood that some infant mortality is avoidable, a relentless focus on identifying and remedying the cause might be thought essential, as part of the general imperative to improve maternity and neonatal services. There appears to have been a move to bring this into sharper focus following the announcement of an ambition to cut mortality by 50% by 2030. Therefore the nature of policy and guidance might be expected to be kept under close review in the next seven years at least.

[151] Child Safeguarding Practice Panel, *"The Myth of Invisible Men" – Safeguarding children under 1from non-accidental injury caused by male carers*, September 2021, https://assets.publishing.service.gov.uk/media/6141e34f8fa8f503bc665895/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf [downloaded 16 May 2023]

7. How are concerns and complaints by parents about the care and safety of neonatal babies dealt with by the NHS and monitored now?

How were they dealt with in 2015? Do you consider that this system is effective now? To the extent the process has changed since 2015 please provide reasons for these changes, in particular by reference to financial resources, staff, regulation and other issues.

7.1 Overview

The NHS Constitution summarises patient's rights in connection with making a complaint. All patients have a right:[152]

- to have an acknowledgement of a complaint made about services in three working days and to have it properly investigated;
- to discuss the manner in which the complaint is to be handled and to know the period within which the investigation is likely to be completed;
- to be kept informed of progress;
- to know the outcome of the investigation;
- to have an explanation of the conclusions;
- to have confirmation of any action to be taken
- to take the complaint to the PHSO if not satisfied with the handling of the complaint;

7.2 There are "*pledges*" in the Constitution of

- courtesy, support and treatment regardless of a complaint having been made;
- explanations and apologies when mistakes have occurred or harm done while treatment being received, delivered with sensitivity and empathy;
- lessons to be learned from complaints.

7.3 The right to complain was enshrined in regulations which require complaints to be:[153]

- dealt with efficiently;
- properly investigated,

and complainants to

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[152] NHS Constitution – Complaint and Redress

[153] The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 SI 309. https://www.legislation.gov.uk/uksi/2009/309/contents

- be treated with respect and courtesy;
- receive assistance in understanding the procedure and advice on where they might obtain such help;
- receive a timely and appropriate response;
- be told the outcome of the investigation; and for
- action to be taken as necessary in the light of the outcome.

7.4 The investigation of a complaint is required to be appropriate to resolve it speedily and efficiently. The responsible body is required to keep a record of each complaint received, its subject-matters and outcome, and whether the required response was sent to the complainant within the prescribed period. An annual report has to be prepared specifying the numbers of complaints received, those decided to be well-founded, referrals to the Ombudsman, and to summarise the subject matter of complaints received. The report has to be made available to anyone asking for it.

7.5 Further obligations were imposed by Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In many ways it overlapped with the 2009 regulations but added a requirement for providers to report on request a summary of complaints received and action taken on them. There was CQC guidance on their expectations with regard to the standards to be observed in the processing of complaints.[154] Failure to provide such a report is an offence.

7.6 I am not aware that concerns and complaints by parents concerning neonatal care have ever been dealt with in any different manner to those raised in any other context of acute hospital care. If any specific arrangements have been made at the level of the individual provider I would not necessarily know about that.

7.7 A massive number of complaints are received in the NHS. In 2022-2023 103,874 complaints to the hospital and community services were received of which 27.6% were upheld.[155] The largest proportion of new complaints received was in the subject area of communication. A relatively small number (2,136, 1.2%) complaints were received about paediatric clinical treatment. The quantity of complaints is not in itself a useful measure: an increase is not necessarily a negative indicator but can be a positive sign that people feel freer to make complaints and vice versa.

7.8 The total number of all reported written complaints about hospital and community health care in 2015-16 was 116,180.[156] This represented a decrease from the previous year.

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[154] https://www.cqc.org.uk/guidance-providers/regulations/regulation-16-receiving-acting-complaints [accessed 18 March 2024] While this page was updated in 2023 I do not believe it had substantially changed since 2015.

[155] NHS England, *Data on Written Complaints in the NHS, 2022-23*. 26 October 2023, https://digital.nhs.uk/data-and-information/publications/statistical/data-on-written-complaints-in-the-nhs/2022-23 [accessed 18 March 2024]

[156] https://digital.nhs.uk/data-and-information/publications/statistical/data-on-written-complaints-in-the-nhs/data-on-written-complaints-in-the-nhs-2015-16 https://files.digital.nhs.uk/publicationimport/pub21xxx/pub21533/data-writ-comp-nhs-2015-2016-rep.pdf [downloaded 23 March 2024]

Nearly 29% were attributable to inpatient services, and 32% were complaints about clinical treatment. 12 sub-categories of clinical treatment were analysed: the largest proportion (12.6%) were attributable to communications, followed by patient care including nutrition. 40.7% of complaints were related to the medical profession, 22% to nursing. Just over 2,000 complaints related to paediatric treatment. Of 14 geographic areas four showed an increase in complaints, including Cheshire and Merseyside. When analysed by age band of patient, the youngest group, 0 to 5 years, was the smallest group: 10,000 complaints were made by parents. Nearly 65% of hospital/community services complaints were upheld in whole or in part. The report indicated that there was a considerable variation in practice as to what complaints were recorded as upheld.

7.9 Chapter 3 of my public inquiry report gives a summary of the history of the complaints system up to 2012. The earlier history was, as I pointed out there, addressed by Dame Janet Smith in the Shipman report.

7.10 I have described the recommendations I made in relation to complaints processed above [recommendations 38,39, 40, 109 to 121] and their implementation. Here, I shall set out in a little more detail what the complaints processes were in 2015 and what they are now, in so far as there is any difference.

7.10.1 At the time of my inquiry the Public Administration Select Committee published a report on the PHSO service,[157] which was critical of the system then in place, in particular with regard to the proportion of cases in which no investigation was ordered. In April 2017 the Select Committee was still voicing its dissatisfaction with the then PHSO:[158]

> *PACAC receives a steady stream of complaints about the quality of the PHSO's investigations, largely complaining about a perceived bias in the investigation process, a lack of involvement of complainants, poor record keeping, and an inability to deal with complex complaints. In its evidence to the Committee, PHSOthefacts, a pressure group critical of the PHSO, raised similar issues. While the then Ombudsman told us she was keen to learn the lessons from dissatisfied complainants, she also warned the Committee against "privileging potentially unrepresentative views.*

7.10.2 It was observed that the PHSO completed fewer investigations, more slowly than previously.

7.11 In October 2013 Ann Clwyd MP, and Professor Tricia Hart[159] published a report on the NHS complaints system, following a review commissioned by the Prime Minister in response to the Mid-Staffordshire report.[160] They made a number of recommendations

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[157] PASC, *Time for a People's Ombudsman Service*, *14th Report of Session 2013-14*, 1 April 2014, HC 655, https://publications.parliament.uk/pa/cm201314/cmselect/cmpubadm/655/655.pdf [downloaded 18 March 2024]

[158] https://publications.parliament.uk/pa/cm201617/cmselect/cmpubadm/1151/115107.htm [accessed 18 March 2024]

[159] Professor Hart had been one of my professional advisers for the Mid Staffordshire Independent Inquiry.

[160] Clwyd, Hart, *A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture* , October 2013, https://assets.publishing.service.gov.uk/media/5a7cb9eb40f0b65b3de0aca7/NHS_complaints_accessible.pdf [downloaded 23 March 2024]

intended to improve the quality of complaints handling and learning, support for complaints and their general experience of the process. They started with recommendations designed to reduce the need to complain and improve the quality of services. With regard to the handling of complaints, having identified reasons for the confusion and reluctance to complain on the part of many, they observed that:

> *There needs to be a change in the way hospital staff approach dealing with complaints. All feedback, including complaints, offer valuable information which can lead to improvements, but there has to be the right organisational ethos to enable this to happen, so that both patients and their friends or relatives and the staff involved feel supported.*[161]

7.11.1 The report recommended improvements to training and response of staff with regard to complaints and in particular the recognition that complaints were essential and helpful information. Better advocacy support was required and Healthwatch should conduct a campaign to improve systems. A number of specific recommendations were made including:

(a) Chief Executives should take personal responsibility for complaints procedure including signing off letters of response.

(b) Boards should lead scrutiny of complaints by way of monthly reports on complaints and the action taken.

(c) Clear standards for complaints handing should be set out. They supported my recommendation that all serious incidents should be investigated independently.

(d) Complainants needed to be involved in a conversation at the outset of the process.

(e) Patient representatives should be involved in the development of complaints processes.

7.11.2 The report also considered issues raised with the review about whistleblowing and expressed concern about the number of unresolved cases of past whistleblowers seeking justice and urged a review of them.. They said:

> *there remains disquiet about the opportunities available for staff to be heard, when they believe there is bad practice both within hospitals, and in the wider regulatory system. There is uncertainty too about what employment protection is genuinely to be offered to future whistle-blowers who reveal their concerns externally to regulators, or the press and media, for example.*

7.11.3 With regard to whistleblowing they recommended:

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[161] Ibid page 33

(a) Clear guidance to staff on how to report concerns, including access to the Chief Executive on request;

(b) A board member responsible for whistleblowing accessible to staff on a regular basis;

(c) A legal obligation to act on concerns raised by staff;

(d) CQC to investigate the ease with which staff could express concerns;

(e) CQC to have a board member responsible for whistleblowing and for ensuring CQC acts on intelligence received from whistleblowers.

7.12 I note that the Countess of Chester's Quality Account for 2013-2014[162] reported that the Trust had reviewed a number of reports, including the Clwyd/Hart review, and that they were "*just*" beginning to implement changes at a local level.

7.13 In November 2014 the Local Government and Health Ombudsmen, together with Healthwatch England, published findings from research into the expectations of service users, patient groups and national bodies, against which organisations should assess their own complaint handling systems and performance. One message was that there was a need for measurement tools allowing services to measure the experience of those wanting to raise concerns or to complain.[163] A Complaints Survey Toolkit[164] responding to this was produced in 2018.

7.14 In January 2015 the House of Commons Health Committee published its report *Complaints and Raising Concerns*.[165] The Committee considered that the handling of complaints remained variable, with too many complainants experiencing poor communication, defensiveness and a breakdown in trust. They condemned the continued bad treatment of whistleblowers:

> *Just as we expect the NHS to respond in a timely, honest and open manner to patients or families raising complaints or concerns, we should expect the same for staff. The treatment of whistleblowers remains a stain on the reputation of the NHS and has led to unwarranted and inexcusable pain for a number of individuals.*

7.15 The Government's response[166] to the Committee's report made clear their expectation that organisations needed to promote openness, and recognise the value of patient complaints and feedback, observing:

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[162] https://www.coch.nhs.uk/media/143128/2013-2014-qual-acct-screen.pdf [downloaded 23 March 2024]

[163] LGO, Healthwatch, PHSO, *My Expectations for raising concerns and complaints*, November 2014, https://www.ombudsman.org.uk/sites/default/files/Report_My_expectations_for_raising_concerns_and_complaints.pdf [downloaded 23 March 2024]

[164] Picker, NHSE, *Complaints Survey Toolkit: Implementation Guide*, https://www.england.nhs.uk/wp-content/uploads/2018/01/surveying-complainants-implementation-guide.pdf [downloaded 23 March 2024]

[165] Health Committee, *Complaints and Raising Concerns*, 13 January 2015, HC 350 https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/350/350.pdf [downloaded 23 March 2024]

[166] DH, Government response to the House of Commons Health Select Committee Fourth Report of session 2014–15 Complaints and Raising Concerns, March 2014, Cm 9050 https://assets.publishing.service.gov.uk/media/5a80504aed915d74e622dbb6/Complaints_Gvt_Resp.pdf [downloaded 23 March 2024]

> *Those organisations that have done most to meet the challenges of the Francis Inquiries are also those that have gone furthest in listening to patients and carers. Whether it is in the Board room, where patient stories play an increasingly important role in reminding organisations of their core purpose and of what really matters, in the home, the clinic or on the ward.*

7.16 Somewhat prophetically they added:

> *The challenge ahead will be to make listening and responding to patients and staff a natural and highly valued element of the culture of the health and care system everywhere.*

7.17 *How were [complaints] dealt with in 2015?*

The regulations cited above were enacted in 2009, and the basis of the complaints system was the same in 2015. The reports cited above, and there will have been many associated publications and discussions within the service on this topic at the time, should have left leaders of any NHS provider in no doubt of the importance being given to patient complaints and staff concerns as valuable and essential tools in bringing about improvements in quality and safety for patients. The statutory framework was a starting point, but minimal compliance with it should not have been regarded as satisfactory or as all that needed to be done. There was, however, unlikely to have been uniformity as between providers with regard to their systems or their resourcing of complaints handling processes, patient advocacy or reporting of complaints and concerns. At national level dissatisfaction was being expressed in the performance of the PHSO in handling complaints.

7.18 *Do you consider that this system is effective now?*

It has been a consistent theme of the numerous reports published since the Mid-Staffordshire report, if not before, that the complaints process was unsatisfactory. Despite the focus on this topic in 2013 to 2015, and efforts in many organisations including the PHSO, to define standards, analyse numbers, offer toolkits, and improve performance, that dissatisfaction has persisted.

7.19 In 2020 Healthwatch England published its report *Shifting the Mindset*, which I have already described in addressing my recommendation 40 above. This found that many NHS Trusts were not publishing satisfactory reports on complaints they had received, and some did not even meet the statutory minimum requirements.

7.20 In the same year the PHSO published a report[167] to Parliament in which he referred to complaints staff having provided him with:

> *A raw picture of a complaints system that is in urgent need of reform and investment…. There is …. acceptance that the current system is not best equipped to resolve the difficulties it faces now.*

7.20.1 This resulted in the PHSO proposing and piloting[168] standards for complaints handling in the NHS in 2021, and then publishing formal standards in 2022, supported by 12 guidance modules.[169] These recognised the value of complaints as a source of learning but noted there had been no single set of guidelines for managing them. The PHSO observed that:

(a) *some organisations do not actively promote a learning culture where complaints are welcomed and used as a valuable source of learning;*

(b) *staff handling complaints do not always get the right training and support;*

(c) *managers and leaders approach learning from complaints in different ways.*

7.20.2 This could, he said, lead to

> *a culture which fears or ignores complaints, rather than embracing them.*

7.20.3 The standards were intended to make sure that:

(a) *organisations promote a learning culture which welcomes complaints and handles them well;*

(b) *staff have the skills and experience they need to be confident in handling complaints*

(c) *people making complaints about NHS services get a consistent, positive experience each time and they;*

(d) *know how to give feedback or make a complaint can get support to do so when they need it are confident that organisations will take any issues raised seriously and take action to address them;*

(e) *staff being complained about are supported and involved throughout the process.*

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[167] PHSO, *Making Complaints Count: Supporting complaints handling in the NHS and UK Government Departments*, 15 July 202, HC 390 https://www.ombudsman.org.uk/sites/default/files/%28HC%20390%29%20-%20Making%20Complaints%20Count-%20Supporting%20complaints%20handling%20in%20the%20NHS%20and%20UK%20Government%20Departments.pdf [downloaded 18 March 2024]

[168] https://www.ombudsman.org.uk/sites/default/files/NHS_Complaint_Standards_2021_22_Pilot_Evaluation_Report.pdf [accessed 18 March 2024]

[169] PHSO, *NHS Complaints Standards*, December 2022 https://www.ombudsman.org.uk/sites/default/files/NHS_Complaint_Standards_Summary_of_expectations_December_2022_Final.pdf [downloaded 18 March 2024]; https://www.ombudsman.org.uk/organisations-we-investigate/nhs-complaint-standards/complaint-handling-guidance [accessed 18 March 2024]

7.20.4 The Ombudsman was implicitly suggesting that these conditions had been absent on many places. In response NHS England consulted[170] on a proposal to incorporate into the 2024/25 standard contract a requirement that provider's complaints procedures comply with the Ombudsman's standards. Subsequently this amendment was included in the substantive contract.[171]

7.21 In 2023 the Ombudsman published a report based on his findings in 22 NHS complaint investigations conducted by his office which found a death had been avoidable. The Ombudsman identified four broad themes of clinical failings leading to avoidable death including failure to listen to the concerns of patients. There was also further, "*compounded*" harm caused by the poor response following harmful incidents . A number of factors were described:

(a) *a failure to be honest when things go wrong*

(b) *a lack of support to navigate systems after an incident*

(c) *poor-quality investigations*

(d) *a failure to respond to complaints in a timely and compassionate way*

(e) *inadequate apologies*

(f) *unsatisfactory learning responses.*

7.21.2 The report pointed to previous criticism that complaints advocacy services are limited to help in navigating the process and are unable to advice on the clinical aspects of complaints. This echoed a finding made in my Mid-Staffordshire report which led me to recommend [recommendation 117] that complaints advocates and their clients should have access to expert advice in complicated cases, which has not been implemented.

7.21.3 A further criticism was made about the quality of investigations: it was noted that in none of the 22 cases reviewed had the provider come to the same conclusion as had the Ombudsman's team, that the death had been avoidable, even though both had access to the same information. In some cases it transpired no investigation had taken place at all. Unacceptable delays in responses were also common, leading to unnecessary distress for the complainants.

7.21.4 While the Ombudsman welcomed the Patient Safety Incident Response frameworks as being excellent, he was concerned that the flexibility and autonomy in approach proposed carried considerable risk in the case off providers with a defensive culture. He recommended a greater external scrutiny, and a review of compliance with the duty of candour.

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[170] NHS England, *NHS Standard Contract 2024/25: A consultation. Proposed changes to the NHS Standard Contract for 2024/25*, December 2023 §13.9https://www.england.nhs.uk/wp-content/uploads/2023/12/01-nhssc-2425-consultation-document-dec-23.pdf [downloaded 16 May 2024]. The consultation closed on 26 January 2024.

[171] NHS England, NHS Standard Contract 2024/25 – technical Guidance §3.2, and page 5 https://www.england.nhs.uk/wp-content/uploads/2024/02/08-NHS-Standard-Contract-2024-to-2025-technical-guidance-version-2-March-2024.pdf [viewed 16 May 2024]

7.22 The Ombudsman has now [15 May 2024] published new good complaint handling guides for the NHS to. Support compliance with the Complaints Standards [and central government organisations].[172] The guidance for the NHS is divided into 14 guides on different topics, such as "*carrying out an investigation*", and "*complaints and other procedures*".

7.23 As has been mentioned, the PHSO office itself has not been free from criticism, and this has persisted. Notably a Patients Association analysis[173] of the PHSO's own data showed little progress since 2016 in improving its service standards, in particular in its ability to explain its decisions, and the time taken to issue a decision, However, the Association noted that there had been improvement in some domains, and that the PHSO had been confronted with a serious reduction in its funding.

7.24 In summary there is evidence that the complaints system has never achieved an overall consistency or effectiveness since 2015 and its application varies considerably between providers. I have not undertaken an analysis of CQC reports to discern the extent to which scrutiny of complaints handling features on their inspections. However, I would expect providers which rate highly for leadership and overall to be handling complaints well, whereas providers with "*unhealthy*" or "*defensive*" cultures are likely to be handling complaints less well. It is clear that the extent to which providers are transparent in reporting the outcomes and learning from complaints received is variable. The "*appeal*" mechanism to the PHSO was not in a satisfactory state in 2015 but has improved to some extent since. The leadership shown by the PHSO in recent times in promoting national standards is welcome, but it is too early to tell whether these will be widely adopted, and the effect if they are. In truth no system of complaints will be effective in promoting learning and safety unless the provider concerned is committed to the learning and safety elements of a "*healthy*" culture.

7.25 It is my personal view that the complaints system is not reliable in satisfying service users and other complainants that their concerns are being properly addressed, that appropriate remediation will be offered, and that deficiencies will be corrected. This is due to a number of factors:

7.25.1 Concerns raised by service users are not invariably perceived as being welcomed when raised initially: many issues could be solved before any formal process is invoked, particularly if healthcare frontline staff were always welcoming of concerns being raised with them and equipped to ensure they were addressed, and if PALS were uniformly user friendly and authoritative parts of the provider's service.

7.25.2 Those raising complaints rarely have access to the support and advice they need.

7.25.3 There is an insufficiently independent element to investigations either in the investigations themselves or in scrutiny of the quality of them.

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[172] https://www.ombudsman.org.uk/news-and-blog/blog/new-improved-guides-good-complaint-handling-nhs-and-uk-central-government [accessed 16 May 2024]

[173] https://www.patients-association.org.uk/Blog/phso-the-facts-and-evidence [accessed 18 March 2024]

7.25.4 Even if there is some initial involvement, complainants are not always involved throughout investigations, and therefore the chances of retaining their confidence in the process is reduced.

7.25.5 There is insufficient transparency in the complaints process, its outcomes and the action taken as a result. Even if the minimum reporting requirements are met, and often they are not, insufficient detail is required to enable an external understanding of a provider's effectiveness as a learning organisation.

7.25.6 The full potential of complaints information as a means of improving safety and quality cannot be realised unless it is processed in a system which amalgamated with information obtained from incident reporting and staff concerns, all of which should be handled with compatible processes.

8. To the extent the process has changed since 2015 please provide reasons for these changes, in particular by reference to financial resources, staff, regulation and other issues.

I am not clear there has been any radical change in how the system provides for complaints to be made or in their processing. There is almost certainly an issue with regard to the resourcing of complaints handling with appropriate, sufficient and well-trained staff, given the time to support complaints and adequate investigation and learning. While the value for safety of complaints is universally recognised, the extent to which that resource is effectively exploited depends entirely on local leadership and culture. At times of extreme demand pressure on services, it might be argued that even more attention is paid to complaints concerns and feedback, but the truth is often likely to be that that less priority is given to this area.

9. **How would you define an effective senior manager**?

Please explain: what leadership qualities and behaviours are necessary for an NHS senior manager both now and in 2015?

9.1 I think it would be helpful to answer these questions together

9.2 I assume that the term "*senior manager*" is intended to refer to a board level leader, in particular a Chief Executive, but also including other executive and non-executive directors.

9.3 When considering leadership requirements in the NHS it is important to understand that there are three aspects of how organisations are run to be considered: leadership, management and administration; they tend to be confused with each other and tom some degree overlap. For example it is often suggested that there are too many "*managers*" in the NHS, or that the administrative burden is too great and so on. Another difficulty is that, as a King's Fund report[174] noted in 2011:

> *Whenever politicians talk about management it is almost invariably a pejorative term.*

I am not sure this is any different in 2024.

9.4 The same report set out a useful summary of the importance of and distinction between the three roles:

> *Management matters. Without it, nothing happens. From deciding on and buying the weekly grocery shop to designing, building and running the giant atom-smasher at Cern, nothing effective happens without budgeting, scheduling and implementation.*
>
> *Beyond that, in any organisation of any size someone – and in a half-decent sized organisation some people – have to provide leadership: setting priorities and a direction of travel, or, in the jargon, deciding the organisation's vision and strategy and engaging staff.*
>
> *In addition, an organisation with good leadership and management will get nowhere without administration, the gritty day-to-day filling-in of forms, ticking of boxes, settling of invoices, issuing of payment notices, providing data to regulators.*
>
> *There is no clear-cut distinction between these three roles. Without leadership there can be no effective management – because the organisation will not know*

[174] Ham et al, *The Future of Leadership and Management. The NHS; No More Heroes*, 2011 The King's Fund, https://www.kingsfund.org.uk/insight-and-analysis/reports/future-leadership-management-nhs [downloaded 10 April 2024]

> *what it is meant to be doing – and without good administration management can be rendered ineffective. The three are interdependent.*

9.5 As they pointed out, somewhat prophetically:

> *… the distinction between the 'front line' and management, or between 'front line' and 'back office', is far from helpful. No surgeon will operate efficiently without a theatre manager. No general practitioner can see patients without a receptionist to arrange appointments and a manager to look after budgets, staff and buildings. And no public health department can prepare for emergencies or plan for a flu pandemic without excellent planning.*

9.6 I would add that both the surgeon and the general practitioners are leaders and managers in their own right as well as frontline providers of services. They direct other staff, prioritise patients by assessment of their needs, and lead departments or businesses in addition to maintaining their own practises. As the 2011 report also observed that leadership in the NHS is needed "*from board to ward*".

9.7 The 2011 report defined leadership as

> *the art of motivating a group of people to achieve a common goal. This demands a mix of analytic and personal skills in order to set out a clear vision of the future and defining a strategy to get there. It requires communicating that to others and ensuring that the skills are assembled to achieve it. It also involves handling and balancing the conflicts of interests that will inevitably arise, both within the organisation and outside it where, even in the private sector, a wide variety of stakeholders will have a legitimate interest.*

9.8 The authors pointed out that leadership required management skills, which they thought was about "*getting the job done*". Leadership involved marshalling the human and technical resources needed to achieve the organisation's goals. In the authors' view the NHS required leaders who could work across boundaries and persuade others as to the right course of action rather than acting as "*super-heroes*" leading a cavalry charge. This meant that the assumption that getting the "*right*" leader was sufficient to change a system or a culture, was wrong. The authors quoted another academic in pointing to one of the essential skills required of a modern leader: the ability to get others to what needs to be done:

> *NHS needs people to think of themselves as leaders not because they are personally exceptional, senior or inspirational to others, but because they can see what needs doing and can work with others to do it.*

9.9 This echoed what Florence Nightingale said:[175]

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[175] Nightingale, *Notes on Nursing - what it is, and what it is not*, 1860

Let whoever is in charge keep this simple question in her head (not, how can I always do this right thing myself, but) how can I provide for this right thing to be always done?

9.10 At the same time leaders need to be people who can "*make a difference*" and can enable all to understand and embrace the values and vision which are required for an organisation to deliver its purpose. They need to be people who can achieve a well-led, motivated, valued, collaborative, inclusive, resilient workforce.[176]

9.11 While these have been the expressed aspirations for what good leadership in the NHS should look like, the reality has not always matched the ambition. A King's Fund report in 2018[177] suggested that leaders were under enormous pressure and stress leading to many vacancies. The average tenure of substantive executive director posts was two years, a figure which was similar to what I was told at the Mid-Staffordshire inquiry. The report suggested there was an association between the brevity of tenure and the level of challenge at an organisation. The tendency was to focus on short term priorities rather than longer term strategy. Trusts rated "*Inadequate*" by CQC had a 14% vacancy rate compared with the 3% rate at Trusts rated "*Outstanding*".

9.12 An attempt to encourage more inclusive, collaborative style of leadership came in 2021 when the NHS Leadership Academy published *Our Leadership Way*,[178] and the *Healthcare Leadership Model*.[179] The first of these Promoted three attributes, compassion, collaboration and curiosity, under each of which are listed multiple attributes. The second has nine "*dimensions*" each of which has numerous prompts for self-reflection.

9.13 There is a great deal of literature on the subject of leadership in healthcare and it would overburden an already lengthy report to refer to it. The brief review I have undertaken for this report and the examples from which I have quoted here, suggest to me that there is no shortage of suggestions about the ingredients required for modern leadership. The problem may be that there are too many. While all point generally in the same direction, they express different approaches which not only may lead to confusion but make assessment of success more challenging.

9.14 With regard to the reality of leadership in the NHS as opposed to the theory, I have to rely on an impression rather than a forensic analysis of the hundreds if not thousands of organisations and their leaders who make up the NHS. That impression is that in the early years of this century the learned leadership culture was one of giving a priority to being responsive to demands coming down from the centre, and of leaders who were part of a self-reinforcing network which encouraged the transmission of positive news while

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[176] See Lord Rose's report, *Better leadership for tomorrow, NHS Leadership Review*, June 2015, https://assets.publishing.service.gov.uk/media/5a7f64e9ed915d74e33f628c/Lord_Rose_NHS_Report_acc.pdf [accessed 10 April 2024]; Messenger and Pollard, *Leadership for a collaborative and inclusive future*, 8 June 2022 https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future/leadership-for-a-collaborative-and-inclusive-future

[177] Anadaciva et al, *Leadership in the today's NHS*, 19 July 2018, https://www.kingsfund.org.uk/insight-and-analysis/reports/leadership-todays-nhs

[178] NHS Leadership Academy, *Our Leadership Way, the Heart, Head and Hands of Leadership*, https://www.leadershipacademy.nhs.uk/organisational-resources/our-leadership-way/ [accessed 10 April 2024]

[179] https://www.leadershipacademy.nhs.uk/healthcare-leadership-model/ [accessed 10 April 2024]

seeking to tackle perceived problems under the radar. Today there is less of a "*club*" among leaders and more awareness of the need for an inclusive, collaborative and patient/staff centred style. However, the systemic pressures can make it very difficult for leaders to adhere to this type of leadership, leading some to revert to the older style.

9.15 In order to answer the question posed to me by the Inquiry I have re-read chapter 24 of the Mid-Staffordshire NHSFT Public Inquiry report on Leadership and Culture. While being aware of the pitfalls of a multiplicity of descriptions mentioned above, I still hold the views expressed there about of what it takes to be an effective leader in the NHS, noting the distinction there drawn between a "*manager*" and a "*leader*". At paragraph 24.24 of that chapter I listed qualities I regarded as required for healthcare leaders. I still regard that list as valid but on reflection would re-order them in order of importance:

(a) Probity;

(b) Courage;

(c) Openness, and candour;

(d) Listening and learning from patients and colleagues;

(e) Inspiration and motivation of colleagues;

(f) Ability to be viewed as a role model;

(g) Ability to create and communicate vision and strategy;

(h) Understanding of how to prioritise and protect patient safety and provision of fundamental standards within available resources;

(i) Willingness to challenge;

(j) Ability to judge and analyse complex issues.

9.16 Needless to say, all these attributes, even if present in an individual, require energy, commitment, compassion and empathy. Success also requires the ability to empower the staff individually and collectively to implement a shared vision and strategy

9.17 I do not consider there should be any significant difference in the qualities and behaviours of a leader which depend on whether they are from a clinical or a non-clinical background.

9.18 A final point on this subject: all guidance and expectation with regard to senior managers and leaders in the public sector derives from the Nolan principles (the Seven Principles of Public Life),[180] first enunciated in 1995:

(a) Selflessness

[180] *Committee on Standards in Public Life, The Seven Principles of Public Life*, 31 May 1995 https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2 [accessed 10 April 2024]

(b) Integrity

(c) Objectivity

(d) Accountability

(e) Openness

(f) Honesty

(g) Leadership

9.19 The Committee on Standards in Public Life, which first enunciated these principles under the then chairmanship of Lord Nolan, has very recently announced a review of one of these principles and it application: accountability.[181] The reason they have given for the review is that:

> *In recent years we have seen several examples of major failures within public institutions, where it seems that opportunities were missed to address issues before they escalated. We are asking, when things go wrong in public bodies, why does it take so long for problems to be recognised and the leadership to respond appropriately and, most importantly, what needs to change?*

9.20 The review will consider:

(a) *How the Nolan Principles can guide decision-making within public bodies.*

(b) *How public bodies can support Parliament, regulators and other bodies to hold them to account on behalf of the public, including but not limited to making available the information necessary for them to do so effectively.*

(c) *Best practice in managing risk within public sector organisations. We will look at how organisations can use data to analyse patterns, identify early warning signs and escalate issues of concern in a timely manner.*

(d) *The role of boards of public bodies, including how they can maximise their effectiveness at providing timely challenge to the organisation.*

(e) *How a healthy organisational culture can help public bodies to learn from their mistakes and take action swiftly to put things right.*

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[181] *Committee on Standards in Public Life launches new review on accountability within public bodies*, 25 March 2024. https://www.gov.uk/government/news/committee-on-standards-in-public-life-launches-new-review-on-accountability-within-public-bodies [accessed 10 April 2024]

9.21 what training do senior managers receive now and in 2015?

9.21.1 I set out my understanding of the training available for senior managers in 2012 in Chapter 24 of my 2013 report and have reviewed some of that in my answers to questions 1 and 2 above – see my observations on the implementation of recommendations on the fit and proper persons test, and on leadership training (recommendations 214 to 221).

9.21.2 It remains the case that there is no standardised requirement for training, experience or qualification for an executive director of an NHS Trust although, as described above, there are many leadership training courses available. Over the years more educational resources have become available for those who wish to use them, and well-run organisations will always attend to the development needs of their senior staff.

9.22 *How are NHS senior managers appraised now and in 2015? Please explain if your answer differs depending on whether an NHS senior manager is a clinical or non-clinical senior manager*

9.22.1 I confess to not being familiar with all appraisal processes applied locally either in 2015 or now, but I have personal experience of those applied to members of the CQC Board. Appraisal of managers has to be distinguished from the appraisals now required of registered healthcare professionals as part of the revalidation process. In this answer I focus on the former. There are a number of sources from which the Inquiry should be able to glean the generality of what was expected, of which the following does not purport to be an exhaustive list.

(a) The Knowledge and Skills Framework and Related Development Review, finalised in 2004.[182] This provided a framework to provide a fair and objective basis on which to review and develop all staff. It contained six "*core*" dimensions and 24 "*specific*" ones, including "*management*". The document should be referred to for the detailed list of four levels, each with between seven to 13 indicators to be reviewed for leadership, and the four levels, each with between seven and ten indicators for management.

(b) In about 2007 a guide for Boards on the Framework was published.[183]

(c) The Institute of Employment Studies review of the NHS Knowledge and Skills Framework in 2010[184] found evidence of a widespread view at the time that while the principles of the 2004 Framework were supported, the inconsistency in its application was unacceptable.

(d) The NHS Staff Council, responding to the review, resolved to simplify and improve the Framework and published a new guide in 2010, which did not withdraw the existing requirements, but sought to supplement them.[185]

(e) In 2013 the NHS Leadership Academy published *The Healthy NHS Board 2013 Principles of Good Governance.*[186] This advocated the importance of whole board and individual appraisal, the latter on an annual basis, and in the case of executive directors to focus on their contribution to the Board separately

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[182] NHS, *The NHS Knowledge and Skills Framework and Related Development Review*, Working draft March 2003, https://dera.ioe.ac.uk/id/eprint/17741/1/dh_4073748.pdf [downloaded 5 April 2024]; NHS, *the NHS Knowledge and Skills Framework (NHS KSF) and he Development Review Process*, October 2004 https://www.msg.scot.nhs.uk/wp-content/uploads/KSF-Handbook.pdf [downloaded 5 April 2024]

[183] NHS, *The NHS Knowledge and Skills Framework – Essential Guide for NHS Boards*, 2007, https://www.msg.scot.nhs.uk/wp-content/uploads/Essential-Guide-for-NHS-boards.pdf [downloaded 5 April 2024

[184] Brown et al, *NHS Staff Council Review of the NHS Knowledge and Skills Framework*, https://www.employment-studies.co.uk/system/files/resources/files/nhse_0410.pdf [downloaded 5 April 2024]

[185] NHS Staff Council, *Appraisals and KSF made simple – a practical guide*, 16 November 2010, https://www.nhsemployers.org/system/files/2021-07/Appraisals-and-KSF-made-simple.pdf [downloaded 5 April 2024]

[186] NHS Leadership Academy, *The Healthy NHS Board – Principles of Good Governance*, 20 June 2013 https://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf [downloaded 5 April 2024]

from any appraisal of their executive role as such. 360 degree reviews were encouraged.

(f) NHS England requires provider Trusts to comply with the Code of Governance for NHS Provider Trusts[187] or explain why they are not doing so. While slightly different provisions apply to Foundation and non-Foundation Trusts the underlying principles are the same. The code is taken into account by the regulators in assessing the Trust's leadership. Paragraph B2.11 of the Code requires the non-executive directors, under the leadership of the senior independent director, to meet at least once a year to appraise the chair's performance. Non-executives also have the duty of scrutinising and holding to account the executive directors individually against agreed performance objectives. (paragraph B2.12). Paragraphs C1.23 and C4.5 require annual evaluation of the board and individual evaluation to demonstrate whether each continues to contribute effectively. In the case of a Foundation Trust there will be "*formal and rigorous*" annual evaluation of the board, its committees, the chair and individual directors by the governors, who may use the senior independent director to evaluate the chair.

(g) A comparison of the NHS Leadership Academy's Leadership Framework and the Knowledge and Skills Framework was published in about 2012.[188]

(h) The Framework for conducting annual appraisals of NHS Chairs 2024[189] introduced a more standardised approach to the annual appraisal of chairs, aligned to the NHS Leadership Competency Framework and informed by multi-source feedback. This is part of a suite of guidance responding to the Kark Review considered above. It observed that:

> *For annual appraisals to be meaningful and contribute beneficially to chairs' personal development, appraisal facilitators should place significant emphasis on developing a highly functional working relationship with their chairs, built on openness, honesty and trust. This will ensure the appraisal does not feel like an impersonal or isolated annual event but an important cornerstone of continuous and supportive dialogue and objective informal feedback, relating to personal impact and effectiveness. Above all, chairs should be genuinely willing to seek and act on constructive criticism about their impact and effectiveness.*

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[187] The versions of which I am aware and have looked at are: Monitor, *The NHS Foundation Trust Code of Governance updated July 2014*, (2014) https://www.fhft.nhs.uk/media/2740/the-nhs-foundation-trust-code-of-governance.pdf [downloaded 5 April 2024]; NHSE, *Code of Governance for NHS provider trusts*, 27 October 2022, updated 23 February 2023, https://www.england.nhs.uk/long-read/code-of-governance-for-nhs-provider-trusts/ [downloaded 5 April 2024], following a consultation draft published on 27 May 2022 - https://www.england.nhs.uk/publication/draft-code-of-governance-for-nhs-provider-trusts/ [accessed 5 April 2024]

[188] NHS Leadership Academy, *Comparing the Leadership Framework and Knowledge and Skills Framework*, 2012, https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Comparing-the-LF-and-KSF1.pdf [downloaded 5 April 2024]

[189] NHS England, *Framework for conducting annual appraisals of NHS chairs (CAF)*, 28 February 2024, updated 21 March 2024, https://www.england.nhs.uk/long-read/framework-for-conducting-annual-appraisals-of-nhs-chairs/ [downloaded 5 April 2024]

(i) NHS Employers have recently published a People Performance Management Toolkit[190] offering practical support to managers to manage their staff. I could see this applying to relatively senior, non-Board members of staff as well as more junior levels. It describes a four-stage process for conducting annual appraisals

9.22.2 These documents suggest that appraisal, sometimes called evaluation, of senior managers, and in particular Board members, has been an expectation throughout the NHS for many years. As, I suspect, in many walks of life, there has been a temptation to consider this a box ticking and somewhat tedious exercise, while the system leadership has sought to encourage a drive towards meaningful, helpful and consistent appraisals. It remains the case that Chairs and Chief Executives are appraised in more detail and externally than other board members and that procedures will vary between organisations. My own personal experience as an appraisee was that appraisals were conducted informally with a somewhat flexible agenda, albeit with a written record being maintained. As a chair of an organisation I tried to use the appraisal of colleagues as a chance to find out from them their thoughts of how the organisation was being run and their part in it, as well as their personal aspirations for the future in terms of personal objectives, with a view to reviewing progress at the next appraisal. I find it difficult to distinguish between 2015 and today except to observe that the quantity of guidance issued over the years can leave no leader in doubt of the importance that should be attached to appraisals as an essential part of corporate governance.

9.22.3 Finally on this question there is a significant difference between a clinical and non-clinical manager when it comes to appraisals. Senior clinical managerial staff will be subjected not only to an appraisal as described here, but also to a regulatory revalidation process. While the latter will be concerned principally with their clinical work, some aspects of their managerial work particularly if it related to the supervision of clinical staff, may feature in both. Whether revalidation as conducted in this country is effective is a matter of continued discussion.[191]

[190] https://www.nhsemployers.org/toolkits/people-performance-management-toolkit [accessed 5 April 2024]

[191] See a news report on a 2018 GMC review: Pulse 1 May 2018, https://www.pulsetoday.co.uk/news/regulation/gmc-review-finds-revalidation-may-not-improve-practice/ ; Goh, *Rapid response to: Appraisal and revalidation for UK doctors—time to assess the evidence*, 9 September 2020, BMJ BMJ 2020;370:m3415 [both accessed 10 April 2024]

10. How are senior managers accountable? Do you consider that is effective? How could it be improved?

10.1 As with the previous answers I assume this question refers to board level leaders and managers. There are various forms of accountability.

10.2 Firstly executive directors and managers are accountable through line management to the Board of their organisation. There will be disciplinary procedures which can be invoked if they are guilty of serious misconduct, or incompetence.

10.3 Secondly, the Board's governance of the management structure and its performance as a Board is open to scrutiny in the case of a Foundation Trust, by its governors. The role of the council of governors is to appoint, and if appropriate, remove the chair, other non-executive directors, and the trust auditor, and to approve the appointment of a chief executive.[192] Additional guidance was published in 2022 to introduce governors to their role in integrated care systems after the passing of the Health and Care Act 2022. In my report [193] I found evidence of significant challenges in the way of governors performing their function of holding Foundation Trust leaders to account effectively. These included weakness of their mandate, lack of authority and experience, lack of clarity among them as to their role, a need for access to external support, and limits on the role of what was then Monitor's advisory council. I made a number of recommendations [recommendations 60 – 78] designed to enhance their authority, support and engagement with the public. Some of this appears to have been implemented in the subsequent guidance, but I have no means of knowing how effective governors have been in reality. There is an inherent tension between their theoretical authority and Monitor/NHS England's powers, which I suspect means that NHSFT Boards will focus more on satisfying the latter than the former. I note that in 2019 NHS Providers started to conduct effectiveness surveys of Councils of Governors, which they back up with a workshop at each Trust surveyed.[194] A 2023 governance survey[195] by NHS Providers was reported as showing that 63% of respondents said they would benefit from extra support to maximise the effectiveness of their Governors. However, only 21% said their system was keen to involve governors as part of their engagement duties.

10.4 Thirdly, Boards are accountable to NHS England as the regulator and licensing authority for providers and to CQC as systems regulator for the assessment of leadership, quality and safety of services. As CQC and NHS England are independent of each other, their priorities have a potential to conflict with each other. In general NHS England has direct

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[192] Monitor, *Your statutory duties, A reference guide for NHS foundation trust governors*, October 2009, updated August 2013 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/284473/Governors_guide_August_2013_UPDATED_NOV_13.pdf [downloaded 25 March 2024]; NHS England, *Addendum to your statutory duties – reference guide for NHS foundation trust governors*, 27 October 2022 https://www.england.nhs.uk/long-read/addendum-to-your-statutory-duties-reference-guide-for-nhs-foundation-trust-governors/ [accessed 25 March 2024]

[193] Mid-Staffordshire NHSFT Public Inquiry report chapter 10 §10.201

[194] NHS Providers, *Council of Governors Effectiveness Surveys*, September 2020 https://nhsproviders.org/media/690203/mark-price-cog-surveys.pdf [accessed 6 April 2024]

[195] NHS Providers, *Governance Survey 2023*, December 2023, https://nhsproviders.org/media/697967/full-governance-survery-23.pdf [accessed 7 April 2024]

powers of intervention, whereas CQC has regulatory enforcement powers. For example, CQC at an inspection may find the standard of a service to be unacceptable, as it has done in recent times with many mental health institutions, but the system often relies on NHS England through intervention or enabling the commissioning of new services before it is practically possible to close down the existing service. NHS England holds provider organisations' leadership to account for meeting targets that it sets, for example the A&E waiting time targets that led to dishonest record-keeping at Stafford Hospital. Where targets are not met, NHS England can and does apply increasingly intrusive "*support*" measures which may culminate in the removal of Chief Executives and Chairs. As the pressures persist again in A&Es concern has been publicly expressed by the deputy Chair of NHS England, himself a former, much respected trust Chief Executive, that the CEOs of trusts failing to meet the target should not be dismissed as they have been in the past.[196]

10.5 Finally CQC monitors the compliance of providers with the Fit and Proper Persons regulation. I have commented on this when addressing the implementation of my recommendations about it [recommendations 79, 80, 81, 82, 83, 84, 85, 86, 218, 219, 220, 221]. Since then the Kark Review reported significant dissatisfaction with the working of this regulation as described there. Now the Health and Social Care Select Committee's expert panel has expressed approval[197] of the recently published Competency Framework, but an Appraisal Framework is still awaited, and Kark's recommendation of a regulatory body has not been accepted. The differing perceptions and experiences offered to the expert panel led them to conclude that the outstanding issues with regard to enforcement and training resources and rate implement here as "*requires improvement*".

10.6 In my opinion, the Fit and Proper Person Regulation is not working effectively as a means of holding directors to account with regard to serious failures in terms of their own conduct or leadership. There remains no universally effective mechanism for ensuring the information and evidence of concerns about directors are objectively, proportionately and fairly investigated and for appropriate action to be taken. There is too much reliance on the existence of good practice at provider level, from within the Board which inevitably faces challenges when concerns are raised about one of its members. Effective external scrutiny depends on action and intervention either by NHS England or CQC. Neither is fully equipped to undertake this task, and as a result there is a risk that unsuitable directors remain in post or are permitted to apply for similar posts elsewhere. I consider that some form of more direct regulation is now required.

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[196] Tidman, *Don't sack CEOs over long A&E waits, warns NHSE deputy chair,* 17 May 2024, Health Service Journal, https://www.hsj.co.uk/emergency-care/dont-sack-ceos-over-long-aande-waits-warns-nhse-deputy-chair/7037155.article [viewed 17 May 2024]

[197] HSCSC, *Expert Panel: Evaluation of the Government's progress on meeting patient safety recommendations*, 19 March 2024, HC 362 https://committees.parliament.uk/publications/44002/documents/217961/default/ [downloaded 23 March 2024]. I am a member of the core panel of independent experts, but stood back from this inquiry in view of my authorship of some of the recommendations being examined, including in this area.

11. How can NHS senior managers provide effective direction on acceptable standards of conduct and practice and support for NHS staff to voice concerns about the quality of care and patient safety in the NHS, in particular in a neonatal unit?

11.1 To some extent this question is answered in the sections above addressing the implementation of my recommendations in the Freedom to Speak Up Review and my answers to questions 4, 5, 6, and 7 addressing openness, transparency and candour, and what a "*healthy*" culture looks like. However the most important and relevant answer is what I have said in answer to question 11 about leadership. In order to provide effective direction on conduct and practice, a leader has to role model the expected behaviours and attitudes and require the same of his staff. To do that a leader needs the qualities I listed there but for convenience repeat here:

(a) Probity;

(b) Courage;

(c) Openness, and candour;

(d) Listening and learning from patients and colleagues;

(e) Inspiration and motivation of colleagues;

(f) Ability to be viewed as a role model;

(g) Ability to create and communicate vision and strategy;

(h) Understanding of how to prioritise and protect patient safety and provision of fundamental standards within available resources;

(i) Willingness to challenge;

(j) Ability to judge and analyse complex issues.

11.2 Not only must an effective leader have those qualities, they must be perceived to have them by those they lead. Each of their subordinates with leadership responsibilities will need to have them as well. Put shortly, staff have to be able to trust their leadership before they will share their concerns frankly with them. They will not trust leaders who tolerate bullying, or, worse, indulge in bullying behaviour themselves. If they see a leader denying what they know to be true or not accepting responsibility for some deficiency they know to exist, they will receive that as a message that they not expected to stand up and tell inconvenient truths. I believe that the tools are largely available to enable effective direction on this subject to be provided by leaders. It is a prerequisite that leaders higher up the hierarchy also conduct themselves consistently with these principles. A failure to do so will compromise the ability of even the most forthright of more local leaders to promote an open culture.

12. **From your experience, what is your view of the quality of communication between NHS management and staff for raising concerns about the quality of care and patient safety?**

Does this differ between different medical professions and grades? Please indicate, as far as possible, the position in 2015 and the position now, drawing on your own reports and other research as you see fit.

12.1 The answer to these questions can be gleaned from those I have given to others, in particular to those concerning the freedom to speak up recommendations, but I will seek to offer an overview here.

12.2 Many of the inquiries listed in Appendix 4 and some others, have exposed instances in which a disaster might have been avoided or at least mitigated, if concerns raised by a member of staff had been listened to and acted on. Instead, in too many cases, the culture of the organisation has either deterred staff from raising concerns, resulted in their being victimised if they do, or in no action being taken in response. In all cases this deficiency has played a significant part in allowing harm to happen to service users. It is instructive to look at some of what was found in inquiries over many decades

12.2.1 In the Ely Inquiry, as long ago as 1969, Mr Geoffrey Howe QC, as he then was, found:

> *an atmosphere had plainly come to exist at Ely in which such well—intentioned members of the nursing staff had been persuaded that it was useless if not hazardous to complain.*

12.3 Two who did so had to leave the hospital. A case was described of a charge nurse threatening a colleague that if they reported incidents they *"would not last long on night duty"*. The Inquiry found that an unfounded charge against this nurse was accepted resulting in their dismissal. Another nurse who made a complaint felt left with no choice but to resign.[198] Mr Howe recommended that nursing staff should be *"accorded a high status and encouraged to take a more active role in the affairs of the hospital."*

12.3.1 The Ashworth Special Hospital Inquiry Report noted that[199]

> *In any organisation there will be "bad apples". The hope is that a culture will exist where such "bad apples" will be exposed and dealt with as appropriate. In Ashworth, it is clear from our independent review team, the external reviewers and our own experience that there is a wealth of talented and committed nurses. However, the absconsion of [a patient] was assisted by a nurse who was considered by many to be corrupt. Nobody blew the whistle. That the Ward Manager had no anxieties about any of his nursing staff, and this nurse in particular, raises concerns.*

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[198] Report of the Committee of inquiry into Allegations of Ill-Treatment of patients and other irregularities at the Ely Hospital, Cardiff, March 1969, Cmnd 3975, Mr Richard Crossman MP in the House of Commons, Hansard 27 March 1969 HC Deb vol 780 col 1808; conclusions and recommendations copied at https://sochealth.co.uk/national-health-service/democracy-involvement-and-accountability-in-health/complaints-regulation-and-enquries/report-of-the-committee-of-inquiry-into-allegations-of-ill-treatment-of-patients-and-other-irregularities-at-the-ely-hospital-cardiff-1969/chapter-13-of-report-on-ely-hospital/

[199] Ashworth Inquiry Report §4.7.26

12.3.2 The Bristol Royal Infirmary Inquiry concerned a scandal about mortality after issues were raised by a consultant anaesthetist who was rebuked for doing so; in spite of his persisting in raising the issue with various senior professionals no action was taken. His concerns were later shown to be substantially justified. He subsequently found it difficult to obtain a post in this country.

12.3.3 The Ayling Inquiry found a defensive culture to complaints and an absence of formal procedures in which to raise them.

12.3.4 The Neale Inquiry found a lack of candour or completeness in references

12.3.5 In the Shipman Inquiry Dame Janet Smith reported that despite the explicit requirements of the GMC in its code of conduct and the strictures of the Bristol Inquiry, a culture of reluctance to raise concerns persisted:[200]

> *It has always been possible for a doctor who was concerned about the treatment given to a patient by another doctor to report his/her concerns about that treatment to an appropriate authority. However, many doctors were not prepared to do that; they had been 'brought up' to regard it as improper to criticise or deprecate the conduct of a fellow professional. The culture was that it was 'not done'. The evidence heard by the Inquiry suggests that, although the GMC had made this quite clear by 1993 at the latest, many doctors were reluctant to make such reports. The old culture lingered on… I was told that events in Bristol had had a salutary effect on the profession, which now recognised that its duty to protect patients had to override loyalty to colleagues. However, in his report of the Inquiry into those events, published in 2001, Professor (now Sir) Ian Kennedy suggested that the old culture among doctors was still alive at that time. Evidence received by this Inquiry suggests that, in some quarters, it survives even today.*

12.3.6 She considered that while it was inevitable that "*deeply ingrained attitudes take a long time to change*" it was important that "*young doctors are imbued with the new culture from the start*" and that leaders "*consistently put the message across to the present generation of doctors*".[201]

12.3.7 Northwick Park maternal deaths: the Healthcare Commission inspectors found, among other areas of concern, a culture of bullying and harassment, and a lack of cultural awareness among staff which affected the quality of care, and poor relationships between staff. Some senior staff were seen as intimidating in style, and some midwives confrontational: not all staff considered this amounted to bullying and noted that short staffing [the existence of which HCC confirmed] increased their stress and contributed to

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[200] The Shipman inquiry, Fifth Report page 20 §73

[201] Ibid page 23 §82

poor communication and relationships. However some staff feared reprisals for raising concerns about the behaviour of their colleagues. [202]

12.3.8 The Kerr/Haslam inquiry uncovered a story of a staff whistleblower whose reported concerns were ignored and who themselves became the focus of disciplinary action without an investigation into the concerns being pursued to a conclusion. The report set out many of the requirements for freedom to speak up later described in my own report albeit in different language.[203] The inquiry considered the difficult issue of what, if anything, needed to be done about the need to report gossip and rumour of serious misconduct. The author observed that:

> *In an area of patent safety such as protection from sexual abuse – or abuse generally – particularly in relation to vulnerable embers of our society, the early detection of incidents, and the early discovery of perpetrators may depend on or be materially assisted by a positive, and proactive response.*
>
> *For that to happen there needs to be a change of culture, so that investigation is welcomed and expected by all, including but not restricted to the NHS staff member (whatever his or her seniority) who is at the centre of the rumour or gossip…*
>
> *… We therefore recommend that the obligation to investigate (certainly in the case of suspicion of the sexual abuse of possibly vulnerable patients) should not require a complaint from one or more named patients, or even identify a named patient…*
>
> *The NHS, as an employer of staff, will be rendered powerless in their task of protecting patients safely unless regulatory bodies also recognise the need to embrace and enforce such policy and guidance.*

12.3.9 This led to the recommendations that the NHS should clarify as a matter of urgency the positive obligation of staff to inform management of concerns about the abuse of patients and the obligation to investigate such concerns without the need for a formal complaint.[204]

12.3.10 Mid Cheshire Hospital NHS Trust Inquiry: the Healthcare Commission inquiry following the conviction of a nurse for the attempted murder of patients found that staff did not feel confident that the Trust always responded appropriately to concerns about poor patient care or performance. While most staff were aware of the whistleblowing policies not all were confident about raising concerns.[205]

12.3.11 Inquiry into the Colin Norris Incidents at Leeds Teaching Hospitals in 2002: this inquiry following the conviction of a nurse for murdering patients found that there were still

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[202] HCC, *Review of maternity services provided by North West London Hospitals NHS Trust*, July 2005 page 7, https://democracy.brent.gov.uk/Data/Health%20Select%20Committee/20061004/Agenda/HCC%20Maternity%20Report%20NWLH%20COPY%20Pages%203%20to%20Only.pdf [downloaded 2 April 2024]

[203] See Kerr/Haslam Inquiry Report page 21 §§51, 66

[204] Kerr/Haslam Inquiry Report chapter 33 §§33.38-33.42

[205] HCC, Investigation *into Mid Cheshire Hospitals NHS Trust*, January 2006, page 20

difficulties with openness and willingness to "*whistleblow*", observing that producing a new policy on the subject will not on its own address a culture where "*a quiet word*" has been the "*preferred style of practice*".[206]

12.3.12 Airedale Independent Inquiry: this was an inquiry, with which the Chair will obviously be fully familiar, into the unlawful treatment of patients by a nurse, who died before she could be tried on charges of murder, attempted murder and administering noxious substances. The Inquiry received evidence that there was a "*club culture*" among some senior managers, and that the nurse in question was perceived to be a member of that. As a result, it was suggested, the culture could not be safely challenged without fear of victimisation. This was something which appears to have contributed to the Board learning nothing of untoward events of which there was no secret at or near the frontline:[207]

> *When members of staff witness unprofessional behaviour going unchallenged, it impacts negatively upon their perception of the way in which the organisation is managed and, potentially, upon their level of commitment. The danger which arises in such circumstances is that effectively a 'bunker mentality' is created; whistleblowing is regarded as too great a risk. Individuals may decide simply to do the minimum required by the organisation and not to concern themselves too much with the actions of others. That is the very antithesis of teamwork.*

The inquiry accepted that the Board and senior leadership of the organisation as a whole had made genuine efforts to obtain staff feedback and to promote an open culture and may have been reassured by their Trust coming within the top 5% in the NHS staff survey of organisations where staff felt they could speak up about bullying and harassment. This led the Inquiry to observe that survey results, good or bad, need to be treated with caution and should not be a substitute for testing morale by other means.[208] Likewise, as seen so often elsewhere, the existence of policies about speaking up and bullying complying with best practice is no guarantee that they are being implemented in real life.[209]

12.3.13 Mid-Staffordshire NHSFT Inquiries: this was in part a story of staff raising concerns which were not heeded, or followed up, and of active discouragement in some cases. There was also stark evidence of victimisation of a nurse who raised concerns about the fabrication of records.

12.3.14 Independent oversight of NHS and DH investigations into matters relating to Jimmy Savile: the Lampard report, which had the benefit of investigations in the many locations

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[206] *Report of the Independent Inquiry into the Colin Norris Incidents at Leeds Teaching Hospitals NHS Trust in 2002*, page 27

[207] *Airedale Independent Inquiry Report* §§5.43, 5.90

[208] Ibid §5.40

[209] Ibid §5.72

of Savile's misconduct, pointed to the difficulties staff, as well as patients and others, had in raising concerns. It identified a number of points requiring attention:[210]

(a) Policies and procedures had to make it clear that they applied to all concerns, not merely ones which might be described as "*whistleblowing*", including concerns of a potentially serious nature for which there was no hard evidence;

(b) Managers had to be approachable to overcome staff reluctance to challenge those who appeared to have authority

(c) Staff had to feel safe and protected from threats and other adverse consequences;

(d) There needed to be flexibility in how concerns could be received;

I observe that the report, correctly in my view, treated the handling of concerns as raising the same requirements for good practice, whatever their source, whether they came from staff or patients.

12.3.15 Morecambe Bay Investigation: Dr Kirkup made an important point about maternity services – and by extension neonatal care – that, much more than other areas of healthcare,[211]

> *the safety of maternity care depends crucially on maintaining vigilance for early warning of any departure from normality and on taking the right, timely action when it is detected. The corollary is that, if those standards are not met, it may be some time before one or more adverse events occur; given their relative scarcity in maternity care, it is vital that every such occurrence is examined to see why it happened.*

Dr Kirkup heard evidence of staff members who had raised concerns which had been resisted by colleagues and led them in their view to being victimised. He made no specific recommendations with regard to "*whistleblowing but noted the recent publication of my own review*."[212]

12.3.16 Liverpool Community Health Independent Review: Dr Kirkup found a dysfunctional organisation in which the staff were "*overstretched, demoralised, and, in some instances, bullied*" leading to significant harm to patients. Staff did not feel listened to, and reporting was discouraged, investigation was poor, incidents were downgraded, and action planning was absent. The pressures on middle management led to an inadequate response, and in some cases bullying of more junior staff. The raising of concerns or grievances was often met by disciplinary processes such as suspension, creating an

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[210] Lampard, Marsden, *Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile*, February 2015, §§4.43 – 4.51, §§13.1 – 13.28. As can be seen from §13.18 I was interviewed by this inquiry.

[211] Kirkup, *The Report into Morecambe Bay Investigation*, March 2016

[212] Ibid §4.1.148 – 1.458

atmosphere in which other staff were deterred from raising their concerns out of fear of the consequences.[213]

12.3.17 Gosport Independent Inquiry: this inquiry largely concerned events occurring in the 1990s but shows that there were unheeded warnings from staff in the 1990s about the use of syringe drivers and diamorphine, an omission which allowed poor practice to continue over many years, and potentially the shortening of life of over 450 patients.

12.3.18 Cwm Taf Health Board: the RCOG review heard both doctors and midwives consistently telling them of reluctance to raise patient safety issues because of a fear of blame, suspension or disciplinary action.[214] This picture was repeated in the subsequent review of the neonatal unit.[215]

12.3.19 Paterson Inquiry: this inquiry noted the many occasions on which healthcare professionals had raised concerns about this surgeon's practice. Investigations were undertaken but all reports appear to have been responded to as if they were isolated incidents. On occasion those who raised concerns which were determined to be unfounded were disciplined. The Inquiry made an important point about the use of HR processes giving rise to a perceived obligation of confidentiality owed to Mr Paterson: [216]

> *Many who gave evidence to the Inquiry commented that HEFT investigated Paterson using HR processes, and this meant that he was guaranteed a duty of confidentiality which stood in the way of patient safety, so patients being treated by Paterson were unaware that there were concerns about the safety of his operations. We believe this approach to have been a mistake, given that patient safety should have been the paramount consideration.*

12.3.20 Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust: the climate of fear at this hospital was such that a number of staff withdrew their support from the Review out of fear of being identified.[217] Fear of identification and victimisation was repeated by many others as a reason for not speaking up at the Trust.[218]

12.3.21 Independent Investigation into Maternity and Neonatal Services in East Kent: Dr Kirkup repeated what he had said about Shrewsbury and Telford maternity services:

> *There is a crucial truth about maternity and neonatal services which distinguishes them from other services provided at hospitals. It is in the nature of childbirth that most mothers are healthy, and, thankfully, their babies will be too. But so much*

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[213] Kirkup, *Report of the Liverpool Community Health Independent Review*, January 2018 Section 1

[214] RCM, RCOG, *review of Maternity Services at Cwm Taf Health Board* January 2019 pages 5, 14, 22

[215] Independent Maternity Services Oversight Panel, *Independent Review of Neonatal Services at Prince Charles Hospital*, January 2022 §6.6

[216] *Report of the Independent Inquiry into the Issues raised by* Paterson, February 2020, Chapter 5 page 135

[217] Ockenden Report, Findings, Conclusion and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, pages viii, 24 §1.55

[218] Ibid page 184 §1.32- 1.36

> *hangs on what happens in the minority of cases where things start to go wrong, because problems can very rapidly escalate to a devastatingly bad outcome.*[219]

This pointed to the need for a greater sensitivity to risk, and to the implications of concerns raised in these services than in the case of less vulnerable patients. The review found alarming deficiencies in the essential cultural underpinning required for a safety culture in which freedom to speak up is such an important part:

(a) Gross failures in teamworking, with some staff acting as if they had separate "*fiefdoms*" cultivating a culture of "*tribalism*" leading to delays in reporting and escalating problems.

(b) Divisions among midwives including bullying causing the service to be unsafe.

(c) Disrespectful behaviour towards mothers and the loss of their babies.

(d) Denial of responsibility or that anything untoward had happened.

(e) Lack of open and frank communication with families.

(f) A tendency to blame junior staff rather than systemic issues for incidents.

(g) A further tendency to replace staff in managerial roles who identified or challenged poor performance.

(h) A repeated turnover of staff at many levels including chief executive.

12.4 Lest it be thought that the cultural deficiencies identified in these inquiries have been historical – and not all have been in any event – the opposite is shown by a brief look at the National Freedom to Speak Up Guardians case review reports:

12.4.1 A review of NHS ambulance trusts published in 2023[220] found a culture permissive of bullying, harassment and discrimination, and cliques stopping people speaking up.

12.4.2 A review of a Foundation Trust in 2021[221] it was found that there had been an improvement in this agenda since 2016, with a current leadership committed to improving its speaking up culture, issues remained, including:

(a) Staff perception of persisting issues

(b) Inconsistent response to concerns raised

(c) Variable quality and consistency of training

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[219] Kirkup, *Reading the signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation*, October 2022 page 2 §1.10

[220] National Guardian's Office, *Listening to Workers – A Speak Up Review of ambulance trusts in England* February 2023, https://nationalguardian.org.uk/wp-content/uploads/2023/02/Listening-to-Workers-Speak-Up-Review-of-Ambulance-Trusts.pdf [downloaded 3 April 2024]

[221] National Guardian's Office, *A case review of speaking up culture and arrangements – Blackpool Teaching Hospitals NHSFT*, October 2021 https://nationalguardian.org.uk/wp-content/uploads/2021/10/Blackpool_Teaching_Hospitals_FT_case_review.pdf [downloaded 3 April 2024]

(d) A persistence of oppressive behaviours

(e) Less confidence in the speaking up culture among black and minority ethnic staff.

12.4.3 A review of another NHSFT in 2020[222] following a complaint by two members of staff found evidence of good practice in the appointment and support of a FTSU Guardian, there were a number of deficiencies, including:

(a) A speaking up policy which did not comply with the national standard and was unclear in a number of respects. This was said to be a finding in every case review of the National Guardian to date.

(b) The role of the local Guardian was not consistently understood throughout the staff.

(c) The board member with responsibility for oversight of speaking did not feel trained or supported in the role.

(d) Staff who spoke up had not been thanked.

(e) Managers required more support in understanding their role in speaking up matters.

(f) A group of workers against whom a grievance was raised were initially told they were not entitled to know what the grievance was about.

(g) A staff member who left after speaking up was not given an exit interview and therefore deprived of a chance to give feedback about the Trust's culture

12.4.4 Patient Safety Learning has recently published an analysis of the 2023 NHS Staff Survey and recent scandals[223] and concluded that, although progress has been made in the production of guidance and information, confidence in speaking up among NHS staff is at an all-time low, recent scandals point to a persistence in a blame culture, and there remains a lack of clarity and focus on the implementation and evaluation of the new national patient safety strategy.

12.4.5 A very recent media report[224] claims that of 52 self-described whistleblower doctors interviewed, 42 had had their own conduct investigated, whereas only half said their employer had investigated the safety concern they had raised, and most said such investigations were inadequate. 45 of the doctors said they had been bullied or subjected to other oppressive behaviour, 22 of them had been reported to the GMC, but in no case

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[222] National Guardian's Office, *Whittington Health NHS Trust - A case review of speaking up learning and actions in response*, June 2020, https://nationalguardian.org.uk/wp-content/uploads/2021/04/2019-casereview-whittington.pdf [downloaded 3 April 2024]

[223] National Patient Safety Learning, *we are not getting safer: Patient safety and the NHS staff survey results*, 26 March 2024, https://www.pslhub.org/learn/patient-safety-learning/we-are-not-getting-safer-patient-safety-and-the-nhs-staff-survey-results-patient-safety-learning-26-march-2024-r11210/ [downloaded 8 April 2024]

[224] Eastham, Rayner, *The four-step 'playbook' the NHS uses to break whistleblowers.*, 16 May 2024, https://www.msn.com/en-gb/health/other/the-four-step-playbook-the-nhs-uses-to-break-whistleblowers/ar-BB1msjwU?ocid=BingNewsSerp [accessed 16 May 2024]

had the complaints against them been upheld. 25 of the doctors had faced disciplinary action, 19 were suspended and 16 were dismissed. While it is impossible on the basis of this sort of report to assess the merits of the grievances of these particular doctors, many more professionals in the service will believe that this is the fate in store for them if they raise a disputed serious concern, and will be deterred from doing so.

12.4.6 These reports and my own experience witnessing the work of the National Freedom to Speak Up Guardian lead me to conclude that:

(a) Most organisations will now have appropriate freedom to speak up policies in place, although in some cases this only occurred some years after the FTSU review report was published, and largely endorsed by the Government and NHS England.

(b) It took a considerable time for there to be near universal coverage within the hospital service for FTSU Guardians to be appointed. There was little uniformity in the terms on which they were employed, or the backgrounds of those appointed. In some cases appointees had the disadvantage of significant conflicts of interest, such as being Board directors.

(c) "*Club*" and defensive cultures have persisted in some places, even within organisations which are overall well-led, meaning that there can be no assurance that in such places matters of concern will be raised.

(d) The extent of the lack of trust on the part of staff that they will be treated fairly, heard and that action will be taken on their concerns can be gauged from the NHS Staff Survey.

(e) The current pressures under which the NHS is working, short staffing, excess demand, long waiting lists, and demands for greater productivity can lead to a lower priority being given to supporting freedom to speak up, as compared with the perceived need to meet the latest demands from the centre.

(f) There is now a coherent patient safety learning strategy, but it has yet to be implemented consistently or to be understood by all working in the system.

(g) There is inadequate accountability for leaderships who do not follow the Freedom to Speak Up principles or victimise those who raise patient safety concerns.

13. Taking into account your answers to the preceding questions, please comment on the effectiveness of the NHS complaints, whistleblowing and patient safety system overall and whether, if you look at how the systems and policies work in practice, whether the system works effectively?

13.1 As all accept, complaints, concerns raised by staff, and patient safety incident reports are all invaluable sources of learning about how to improve the way things are done. All three sources only lead to improvements in safety and quality if a number of things occur as a result, including:

(a) Objective, independent, proportionate and fair investigation to find out what happened and how it happened involving all concerned in a joint effort to work this out.

(b) Freedom from fear and pressure to conceal information for all service users, those close to them, and staff.

(c) Collective commitment to put right as far and as quickly as possible any harm done, through truthful explanation, appropriate apologies, and acknowledgement where appropriate that harm was avoidable, and material and if necessary financial support for those directly affected.

(d) Treating these processes as part of the therapeutic relationship and therefore a joint undertaking on the part of staff, the provider and service users to collaborate with each other to achieve a satisfactory outcome.

(e) Above all to what is reasonably practicable to maintain a relationship of trust between those who have provided and those who have received the relevant treatment and care.

13.2 To date I do not consider that any of these processes has achieved these features with any degree of consistency or universality. Each of these processes is subject to differing policies, organisational arrangements, resources, and accountabilities. I suggest they would all be much more effective if it were recognised that they share many of the same requirements with regard to values, attitudes, skill and outcomes, and provided for jointly.

14. **Are there any examples you would highlight (nationally or internationally) which demonstrate a best practice response to concerns for patients within healthcare**?

What are the features of any such case study that we can learn from? Are there any particular best practice responses relating to a neonatal unit?

If I may I would like to consider this question and offer a later supplementary report. I suspect it is difficult to find an instance which offers a permanent solution to all the issues that have been highlighted here. Some of them are universally experienced internationally. For example the error rate in medicines is too high in many countries. However I am confident it will be possible to find an evidence base through case studies of places where a health and open culture has been successfully installed.

15. What recommendations do you think this Inquiry should make in the light of its terms of reference under C? In answering this question, please draw on your own experience from previous reports and the answers you have given to the earlier questions.

15.1 I hesitate to answer this question without the better knowledge of events at the Countess of Chester from which undoubtedly further learning is to be drawn. In so far as the question directs me towards more general answers, taking account of Dr Kirkup's observations about inquiry recommendations, I would caution against adding to the library of recommendations pointing in the same direction but in different words. I believe that, taking together the reports considered in this report, it can be seen that there is remarkably little substantial difference in the view of the direction of travel that should be taken. There have been perceptions that there is a difference between those who favour regulation and those who favour cultural change as "*the*" answer. In my opinion, as I hope is evidenced by the recommendations I have made in the past, both are necessary, and neither is sufficient. We know what regulation can and cannot achieve, and we know what sort of leadership – leadership at all levels of the system, from national to the bed-side – is required to produce the required culture. The challenge is to see both these achieved throughout the system consistently, and permanently.

15.2 One feature of all the inquiries considered in this report is that they arise out of a disaster at one organisation which has therefore been the focus of the inquiry along with an examination of how the system around it acted in that particular case. It may be that this does not always allow a holistic a view of what is required to achieve the relevant change. It has been my experience in the last ten years that while the rhetoric is always broadly aligned with the direction of travel mentioned above, action does not always follow the words. It is legitimate to ask why this is the case. One slightly superficial answer is that the healthcare system is vast, comprising of many different and at least semi-autonomous organisations, often with multiple lines of accountability, and one of the largest workforces in the world. A second issue is that any change has to be inserted into a service which can never halt as might a car or a ship for a refit. These may be reasons why reform pronounced from the centre, either by government or the NHS national

leadership, hit barriers to progress. One mantra I have become accustomed to hearing when new proposals are being discussed is that "*it is too difficult*". I have come to the conclusion that cultural change is unlikely to occur through pronouncements from on high alone but must be agreed to and demanded by service users, their representatives and front-line staff, coming together to implement change which they see can make the difference locally. The task of the more strategic part of the system should be to remove rather than erect barriers to progress and incentivise positive change through measurement of the outcomes that are important to service users and staff. Therefore, with considerable hesitation, given the history of unintended consequences from past re-structuring, I now consider that the NHS does need to be re-organised so that change can be effected locally with local accountability and minimal interference from a centralised hierarchy,

15.3 In suggesting this approach, it should not be assumed, that either service users or staff are necessarily motivated to act objectively in the general public interest. Patients are understandably likely to focus on the treatment needs of their particular diagnostic groups. Staff perspectives will inevitably be influenced by the interests of their particular professional group. Both types of self-interest are understandable, and indeed are a necessary factor, in deciding on change which will affect many different groups. At the moment, however, these interests are likely to be allowed to cancel each other out and prevent change which would actually benefit both. A typical example might be a proposal to improve outcomes by transferring a local specialist service to a more national centre of expertise, which is then opposed by patient groups wanting the convenience of a service near where they live and by healthcare specialists who do not want to move. I suggest that the obstacle of patients' self-interest would be mitigated by a more extensive engagement with the public about health issues, involving them in real as opposed to formalistic consultations, supported by objective information which they could not only understand but trust. The professional interest requires the walls between specialties and professional groups to be made more porous, so all come together to address issues of general application to their patients. The issues which have been the subject of this report are largely ones which apply throughout the service and are not confined to a particular specialty, even if the effects may be much more serious in some rather than others. So mistakes and absence of safety precautions may have significantly more serious consequences in a neonatal intensive care unit, than in a minor injuries clinic, but the principles required to generate a healthy safety culture are likely to be the same. It is too easy for one specialty to reject a proposition because the evidence supporting it does not originate within it, even more so when the example given is from outside healthcare altogether. This tendency towards silo thinking needs to be recognised and addressed where it is an obstacle to positive progress. It is surely one of the tasks of a leader to ensure that their organisation's cultural demands embrace professional and other sub-cultures but are given priority by all within that organisation.

15.4 As a start towards a cultural world where these obstacles are overcome I would suggest two high level approaches of universal application:

15.4.1 All strategic decision-making bodies [e.g. Integrated Care Boards] and all frontline service provider organisations should be required to introduce service users and their

representatives into all their organisational decision-making processes and demonstrate that they have been equipped to be full informed participants in the decisions being taken. It could be made a priority for regulators to ensure that this was happening, and that the wisdom of service users and the public was effectively included throughout in decision making processes and at all levels of the system.

15.4.2 The skills required to work together with and to listen to members of other healthcare professions both in their daily teamwork and also in their participation in addressing common issues need to be included as important requirements for training and professional development. Professionalism and teamwork in this sense is urgently required, and all too often missing in our healthcare. Part of this is due to the way in which healthcare professions are regulated, largely by separate regulators, and different codes of practice. As the GMC has observed recently and not for the first time:[225]

> *The laws that govern how we regulate doctors have not kept pace with the changing needs of the healthcare systems in which the professions work, and with society's expectations of modern regulation. Some of our legislation has its origins in the 19th century. And, although it has been updated at various times, the result is a regulatory framework that is complex, overly prescriptive, and slow to adapt to change.*
>
> *As individual healthcare professionals increasingly work together as part of wider multidisciplinary teams, the differences and disconnections between the way that each profession is regulated have become all too apparent. This lack of consistency and co-ordination has hampered regulators in their efforts to protect the public and support those we regulate in delivering great care*

While this comment was made in the context of the regulation of physician and anaesthesia associates, it applies equally to the regulation and support required for all healthcare professionals in relation to their obligation to work together as a team.

15.5 I would like to make one final point about the particular focus of this Inquiry, namely neonatal services. As the quotations I have made from the reports of Dr Kirkup make clear, maternity and neonatal services involve not only healthy and well mothers, but in their babies, both before and immediately after birth, the most vulnerable members of society, who risk losing their entire life or facing lifelong serious disability, if they are not protected within a truly safe environment. While not unique in this regard, I suggest it should mean that the tolerance of risk and unexpected outcomes should be significantly less in this area of the service than in some others.

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[225] GMC, *Regulating Anaesthesia Associates and Physician Associates - Consultation on our proposed rules, standards and guidance*, 26 March 2024 https://www.gmc-uk.org/pa-and-aa-regulation-hub/regulating-aas-and-pas-consultation [downloaded 2 April 2024]

16. STATEMENT OF TRUTH

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true.

Personal Data

[SIGNED]

[DATE] 30 May 2024

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