NHS Confederation

Health and Social Care Committee Inquiry on NHS leadership, performance and patient safety

March 2024

About us

The NHS Confederation is the membership organisation that speaks for the whole healthcare system in England, Wales, and Northern Ireland. Our members employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care, and reducing health inequalities.

NHS Employers is hosted by the NHS Confederation and supports NHS organisations in England to develop a sustainable workforce, improve staff experience and be the best employers they can be.

How effectively does NHS leadership encourage a culture in which staff feel confident raising patient safety concerns, and what more could be done to support this?

1. The NHS has strengthened mechanisms to support staff to raise patient safety concerns since Sir Robert Francis QC's report into the serious failings that took place at Mid Staffordshire NHS Foundation Trust[1].

2. The report made a series of recommendations on increasing support for staff to raise patients safety concerns, culminating in a new patient safety framework[2] and the development of the National Guardian's Office (NGO). The NGO provides support to Freedom to Speak Up (FTSU) Guardians who work across the NHS to create a culture where people feel they can speak up and that their voices will be heard. NHS Employers support the NGO by sharing expertise, disseminating resources with members and raising awareness of their work with NHS trusts[3].

3. NHS England (NHSE) has also developed new procedures to support whistleblowing through the national FTSU policy for the NHS[4], and there has been a greater focus on this issue in the performance regulation regime and in the NHS Staff Survey. NHS Employers has supported NHSE in these endeavours and has a work programme that raises awareness of whistleblowing including best practice and key learnings for employers to consider[5].

4. Following these initiatives, data from the NHS Staff Survey in the period of 2017-2019 indicated modest progress on addressing whistleblowing concerns as NHS organisations developed their own FTSU policies and established the role of FTSU Guardians[6]. As part of the People Promise Framework published in 2019, raising patient safety concerns became a key metric for measuring staff experience of working in the NHS via the NHS Staff Survey[7].

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[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry
[2] https://www.england.nhs.uk/publication/framework-for-involving-patients-in-patient-safety/
[3] https://nationalguardian.org.uk/about-us/
[4] https://www.england.nhs.uk/publication/the-national-speak-up-policy/
[5] https://www.nhsemployers.org/articles/freedom-speak-employer-actions
[6] https://www.nhsstaffsurveys.com/results/results-archive/
[7] https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/

5. Progress continued to be made on addressing whistleblowing concerns during the pandemic, with staff confidence on raising concerns about patient safety issues rising from 72 per cent in 2020 to 75 per cent in 2021[8]. However, the NHS Staff Survey for 2022 showed a big drop in confidence to 71 per cent which has almost reversed progress that was made. Furthermore, there was also a less steep but parallel fall in confidence that action would be taken where issues were raised[9]. The results from the latest NHS Staff Survey for 2023 remained broadly stable in these areas[10]. Members report that, in part, this reflects staff concern regarding the responses to growing pressure on services and longer waits for many patients than most staff have ever experienced.

6. NHSE and the NGO have taken steps to address this drop in confidence through strengthening national guidance. This has included updates to the national Patient Safety Framework[11] and FTSU policy for the NHS whilst offering more training and support for FTSU Guardians[12]. There have been some signs of progress in recent Care Quality Commission (CQC) reports[13], highlighting the important role employers can play in empowering NHS staff to access and use whistleblowing resources to build a better culture in their organisation.

7. Positive work on developing a 'just culture' in many NHS trusts is ongoing, supporting managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way[14]. The CQC is also increasingly focussing on this issue in its recent inspections of NHS organisations[15].

8. In addition, NHS Employers has developed a range of resources for members which share key learnings and outline how senior leaders and line managers can embed a healthy speaking up culture in the NHS[16].

What has been the impact of the 2019 Kark Review on leadership in the NHS as it relates to patient safety?

9. The Fit and Proper Persons Test (FPPT) which was reviewed by Sir Tom Kark QC in 2019 made seven recommendations to strengthen the assessment[17]. Most recommendations have since been taken forward by NHSE including the development of a new framework and resources to support senior board members to strengthen governance, leadership and improve patient safety[18]. The outstanding recommendations regarding a disbarring mechanism for managers found guilty of misconduct are likely to feature in recommendations to be made by Lady Justice Thirlwall who is examining the events that took place at the Countess of Chester Hospital[19].

10. More recently, NHSE published a leadership competency framework for all board members of NHS providers, Integrated Care Boards (ICBs) and NHSE. The NHS Confederation including NHS Employers contributed to the development of the

[8] https://www.nhsstaffsurveys.com/results/results-archive/
[9] Ibid
[10] https://www.nhsstaffsurveys.com/results/national-results/
[11] https://www.england.nhs.uk/publication/framework-for-involving-patients-in-patient-safety/
[12] https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/
[13] https://www.cqc.org.uk/provider/RW5
[14] https://www.england.nhs.uk/patient-safety/patient-safety-culture/a-just-culture-guide/
[15] https://www.cqc.org.uk/news/our-new-assessment-approach-assessing-well-led-key-question-nhs-trusts
[16] https://www.nhsemployers.org/articles/embedding-healthy-speaking-culture
[17] https://www.gov.uk/government/publications/kark-review-of-the-fit-and-proper-persons-test
[18] https://www.england.nhs.uk/2023/08/new-standards-for-nhs-board-members-to-strengthen-leadership-and-governance/
[19] https://thirlwall.public-inquiry.uk/

framework which will help with the appointment of diverse, skilled and proficient leaders and support the delivery of high-quality and equitable care[20].

11. It is important that any action which aims to improve patient safety enables a consistently experienced cultural shift in the way the NHS and its professions address these issues. There needs to be less emphasis on blame and more focus on the creation of 'safe spaces', where clinical and managerial staff can voice their concerns and report honest mistakes without fear of reprisal. A measured approach that places a greater focus on the ongoing development of senior leaders (executive and clinical) rather than on disciplinary levers will yield better results as the NHS delivers new models of care, notwithstanding wilfully criminal or malicious behaviour.

12. The NHS Confederation has worked to support the leadership role of Integrated Care Systems (ICSs), through our Connected Leadership Programme for Integrated Care Board (ICB) Chairs, ICB Chief Executives and Integrated Care Partner Chairs[21]. Fulfilling the potential of ICSs will require a new type of leadership which this programme has been set up to grow.

13. Our leadership development programme will help build community, ignite collaboration, spread innovation and grow networks among NHS leaders and support them to improve the services they provide to local communities which patient safety is at the heart of. The NHS Confederation also jointly runs the Leading Integration Peer Support Programme (LIPS) with the Local Government Association and NHS Providers[22], and the System Improvement Programme with the Health Foundation's Q Community[23].

14. NHSE is also supporting these changes through its national improvement approach, NHS IMPACT[24], NHS Leadership Academy[25] and work to embed its new operating framework[26]. Embedding these changes will take time and require sustained commitment from within ICSs, government and national organisations which will be challenging in the context of current operational and financial pressures.

What progress has been made to date on recommendations from the 2022 Messenger Review?

15. The Messenger Review has placed a welcome focus on NHS leadership and management; a vital element of delivering quality care.

16. The review, undertaken with Linda Pollard, addresses many of the asks that our members fed back to the review team, including practical recommendations for more structure and consistency in leadership development; promotion of collaborative behaviours; and a greater commitment, backed by tangible action, to promoting equality, diversity and inclusion in leadership roles[27]. Its acknowledgment of the importance of shared values in system working was welcome, though there was disappointment that the review did not go further in addressing the needs of primary care and social care. That remains unfinished business the government should not overlook.

[20] https://www.england.nhs.uk/publication/nhs-leadership-competency-framework/
[21] https://www.nhsconfed.org/publications/connected-leadership-unique-learning-community-ics-leaders
[22] https://www.nhsconfed.org/what-we-do/peer-support
[23] https://www.nhsconfed.org/improvement-support/learning-improving-systems
[24] https://www.england.nhs.uk/nhsimpact/about-nhs-impact/
[25] https://www.leadershipacademy.nhs.uk/organisational-resources/support-for-integrated-care-system-development/
[26] https://www.nhsconfed.org/publications/nhs-englands-new-operating-framework
[27] https://www.nhsconfed.org/publications/messenger-review-health-and-social-care-leadership-what-must-it-address

17. For the Messenger Review to make a difference, the requisite funding, support and resourcing must be provided by government to ensure leaders across social care and health can deliver on its recommendations.

18. It is important to note that high-performing health systems require investment in effective management and the NHS continues to be under-managed in comparison to other sectors[28]. Channelling investment away from management and administration forces busy clinical professionals to pick up non-clinical tasks which is counter-productive, serving to exacerbate the workforce crisis and prevent innovation, improvement and growth in productivity. NHS managers should be viewed as part of the solution to the systemic challenges facing the health service.

How effectively have leadership recommendations from previous reviews of patient safety crises been implemented?

19. In the twenty years since the inquiry into failings at Bristol Royal Infirmary[29], there has been a sustained focus on improving patient safety, reducing harm and effective governance. However, progress is though uneven and at times erratic. The pattern of failings in, for example, maternity services reminds all leaders, executive and clinical, of the profound challenges that remain.

How could better regulation of health service managers and application of agreed professional standards support improvements in patient safety?

20. Our members accept that regulation of senior leaders across health and social care is now inevitable, and that it will enhance confidence in accountability for patient safety across all areas of leadership.

21. During recent engagement with members on this topic, they have been clear that any framework which regulates senior health and care leaders must have a clear purpose. Any form of regulation must, it is clear, be founded upon principles of public safety, promotion of standards and professionalism and continuing professional development. The regulatory processes must be defined by independent decision making, transparency and natural justice, and must apply to all parts of health and social care, not just NHS provider organisations. It must also be enacted within the context of wider regulation, and recognise that some health and social care board members are already subject to professional regulation via the Nursing and Midwifery Council, General Medical Council and some accountancy bodies.

22. Regulation needs to be against a clearly stated and understood set of standards which is set out as a ‘Code of Practice’ for some professions. Much work has been done on variations of this approach over the years in the NHS across the UK, and it is important that any new regulator moves quickly to propose and consult upon these standards. Many leaders respond positively to this discussion of standards and see their formalisation via a regulator as a reinforcement of the professionalism of the role of leaders in health and social care.

23. The experience of other regulated professions shows that many of the concerns raised with the relevant authority do not necessarily merit investigation and formal intervention by that regulator. Often, issues are best dealt with by the relevant employer or a service regulator. The process of assessing complaints is therefore a crucial element of the regulator’s role and needs to command the confidence of the

[28] https://www.nhsconfed.org/articles/are-there-too-many-nhs-managers
[29] https://www.bristol-inquiry.org.uk/final_report/index.htm

public as well as those that are subject to regulation. Other regulators also report disproportionately higher complaints against black, asian and ethnic minority staff, and particular care will need to be taken to prevent this being replicated in a new process for leaders.

24. The application of regulation to small primary care and social care providers who, whilst inspected and regulated by the CQC, do not have board structures seen in larger health and social care organisations, will need careful consideration.

How effectively do NHS leadership structures provide a supportive and fair approach to whistleblowers, and how could this be improved?

25. To make the NHS the best place to work and a modern employer of choice, staff need to feel safe and confident when speaking up and trust that they will be listened to, including allowing time for reflection and learning when things go wrong. This drives improvement and can lead to better outcomes for staff and patients.

26. Therefore, working to foster a speaking up culture forms part of a NHS leaders wider efforts to embed a compassionate, healthy work environment that supports workforce wellbeing. To support them, NHS Employers has published a resource outlining how leaders can embed a healthy speaking up culture in the NHS[30].

27. Alongside this, there is a need for NHS organisations to have clear and trusted systems and processes in place to support the handling of whistleblowing concerns and staff complaints. To support NHS organisations to improve their whistleblowing procedures, NHS Employers has developed resources which promote good practice[31] and hosts regular webinars to support HR practitioners working in the NHS to reflect on their organisation's current whistleblowing procedures and identify where improvements can be made[32].

How could investigations into whistleblowing complaints be improved?

28. The national FTSU policy for the NHS, which was recently updated by NHSE, provides the minimum standard for local FTSU policies across the NHS, and its consistent application will help improve investigations into whistleblowing complaints.

29. All NHS trusts and Foundation Trust Boards were asked by NHSE to update their local policies to reflect the new national template by the end of January, which will help staff working across the NHS to understand how to speak up and what will happen when they do.

30. Investigations into whistleblowing complaints are improved by upskilling senior leaders, HR directors and line managers to better apply policies and procedures around whistleblowing including clear communication and feedback to staff who have raised concerns. Organisations do also make use of independent, external investigators and advisors where relevant. Medical Royal Colleges, for example, play an important role in reviewing concerns relating to clinical services through the process of *Invited Reviews*[33].

31. Members provide positive feedback regarding the e-learning training package offered by the NGO on *Speak Up, Listen Up and Follow Up* and put this training into

[30] https://www.nhsemployers.org/articles/embedding-healthy-speaking-culture
[31] https://www.nhsemployers.org/articles/freedom-speak-employer-actions
[32] https://www.nhsemployers.org/events/whistleblowing-procedure-policy-and-good-practice
[33] https://www.aomrc.org.uk/invited-reviews/

practice[34]. Access to this package for all managers and leaders, clinical and executive, will help those colleagues to understand what role they can play in encouraging a healthy speaking up culture for patients and staff.

32. Following the verdict that was reached in the trial of Lucy Letby, NHSE made five recommendations in a letter that was sent to all ICBs, NHS trusts, Primary Care Networks and regional leads on how NHS organisations can have more accessible and effective speaking up arrangements which will help improve the whistleblowing complaints process if fully implemented[35].

33. Finally, the CQC consistently observes that organisations with the strongest staff engagement scores, as reported by the NHS Staff Survey, have the best overall approach to patient care, risk and safety[36]. 'Speaking Up' is part of a wider range of leadership actions designed to maintain effective workplaces. For example, it is important that key learnings from adverse events are identified and shared with employees.

How effectively does the NHS complaints system prevent patient safety incidents from escalating and what would be the impact of proposed measures to improve patient safety, such as Martha's Rule?

34. NHS leaders support the introduction of new ways to enhance patient care, improve patient safety and save lives and will welcome the roll out of 'Martha's Rule'. It is right for the NHS to learn lessons from cases such as these and to take steps to try to prevent avoidable deaths.

35. There are already places across the country that have introduced similar policies. These trusts have seen a fall in complaints as well as only a small proportion of patients feeling it necessary to escalate issues.

36. Questions remain about what resources hospitals and other providers will be given to deliver the new scheme if it is later expanded across all acute hospitals. Introducing a 24/7 clinical review process will have implementation costs and leaders will be concerned if they are just being expected to provide the additional service without any extra resources.

37. But this roll out is part of an important shift where the NHS is looking to change the relationship between the health service, clinicians, patients and their families. The future model of care is one where patients and their families are active partners in healthy communities, not just consumers of NHS services.

What can the NHS learn from the leadership culture in other safety-critical sectors?

38. It has long been the case that clinical and executive leaders, in taking action to improve the quality and safety of healthcare, have drawn on learning from other industries including high reliability organisations, aviation and manufacturing. This has informed the long-standing application of quality improvement methodologies and driven the widespread adoption of approaches such as, for example, incident reporting, root cause analysis, the use of simulation training in clinical education, and approaches to structured communication such as the development of checklists.

[34] https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/
[35] https://www.england.nhs.uk/long-read/verdict-in-the-trial-of-lucy-letby/
[36] https://www.england.nhs.uk/long-read/safety-culture-learning-from-best-practice/

39. These principles have been adapted and applied to healthcare settings, and there is rich learning from around the world about this work. The *Science of Improvement* work of the US based Institute for Healthcare Improvement (IHI) is important as is the long-term work of the Q Community in the UK. The NHS Confederation is working in partnership with the Q Community to ensure that systems are able to apply large scale improvement methodologies to benefit the populations they seek to serve[37].

40. At the same time there must be recognition that approaches from other industries need to be carefully adapted to the particular context and complexities of healthcare delivery[38]. Thoughtful adaptation is needed.

[37] https://www.nhsconfed.org/improvement-support/learning-improving-systems
[38] https://www.bmj.com/content/364/bmj.l1039