Department of Health

Consultation on the implementation of the recommendations, principles and actions set out in the report of the Freedom to Speak Up review

March 2015

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Executive summary

This Government wants to ensure that the NHS is the safest and most transparent healthcare system in the world. To achieve this, individuals must feel safe to speak out and raise concerns. In addition, action must be taken when concerns are raised.

The tragic and inexcusable failings at Mid Staffordshire NHS Foundation Trust highlighted the need for a change in culture to encourage staff to raise concerns. In other parts of the NHS, it was clear that in some wards and in some weaker institutions there were also worrying cultures allowing a failure to face up to problems and deal with them, letting down patients and staff alike.

In response to concerns about the reporting culture in the NHS, the Secretary of State for Health commissioned Sir Robert Francis QC to carry out an independent policy review, "Freedom to Speak Up".

The review was asked to identify measures to help to foster a culture in the NHS in England where staff can feel safe to speak out about patient safety, as well as learning lessons from the existing culture in the NHS by listening to those who have experiences to share, both positive and negative.

The report of the review was published on 11 February 2015, with two high-level recommendations:

1. All organisations which provide NHS healthcare and regulators should implement the principles and actions set out in the report in line with the good practice described in the report.

2. The Secretary of State for Health should review at least annually, the progress made in the implementation of these Principles and Actions, and the performance of the NHS in handling concerns and the treatment of those who raise them and report to Parliament. The Secretary of State has agreed to this recommendation.

The Secretary of State has accepted the recommendations in principle. This consultation seeks views on a package of measures to implement the recommendations.

Background

In his report, Sir Robert has challenged the NHS in England, and those that regulate it, to sign up to a set of twenty key principles, which will form the foundations on which we can build a consistently open and transparent culture - where staff are able to raise concerns confident in the knowledge that they will be listened to, that action will be taken, and that they will be thanked and acknowledged for living their professional values and the values of the NHS. Sir Robert also set out a programme of actions that follow from each principle.

The twenty principles and associated actions are grouped into five themes:

- Culture change;
- Improved handling of cases;
- Measures to support good practice;
- Particular measures for vulnerable groups; and
- Extending the legal protection.

The Secretary of State has accepted the recommendations in principle, and committed to consult on a package of measures to implement them. In practice, this means consulting with local NHS healthcare providers and national regulators and oversight bodies (as well as with patients and those who have been involved in whistleblowing) on how they can best implement the principles and actions, since the vast majority of those principles and actions require local implementation.

A copy of the recommendations, principles and actions is at Annex A.

The full report can be viewed at www.freedomtospeakup.org.uk

Introduction

1. We are now undertaking this public consultation to ensure that we honour the spirit of what Sir Robert has recommended but also avoid unnecessary layers of bureaucracy or financial burden. We expect that national regulators and oversight bodies and local NHS healthcare providers will need to consider and review how best to implement the principles and actions contained in the report in an effective, proportionate and affordable way, consulting with stakeholders themselves as appropriate.

2. There are many of the principles and actions that we expect can be taken forward immediately, building on what is already in place locally. We would encourage both local and national NHS organisations to move ahead with such actions without further delay.

Local implementation

3. We agree with Sir Robert's assessment in his report that "*local action and responsibility is at the heart of bringing about a culture where reporting of concerns is valued and encouraged*". In the past, when things have gone wrong, too often the system has failed to either notice or to acknowledge what was happening and to take action to prevent poor or unsafe care from reoccurring.

4. For things to change and to make a positive impact on patient safety and improve care, changes need to be made quickly at a local level. The vast majority of the actions in the report reinforce local accountability for changing culture, backed by the national role of the system regulators.

5. The first question on which we are seeking views is, therefore, about the approach to implementing the findings of the report at a local level.

Question 1: ***Do you have any comments on how best the twenty principles and associated actions set out in the Freedom to Speak Up report should be implemented in an effective, proportionate and affordable way, within local NHS healthcare providers?***

In considering this question, we would ask you to look at all the principles and actions and to take account of local circumstances and the progress that has already been made in areas highlighted by "Freedom to Speak Up".

Role of national bodies

6. Within many of the principles and actions is a role for the national regulators and bodies that oversee the NHS and healthcare provision in England. For each of the principles and actions where these national bodies have a role, we expect that they will separately consult on their plans and any guidance. We expect that these consultations will be published by summer 2015. In particular, there will be consultations on:

    - How to apply the principles in the report to primary care
    - The approach to implementing the principle on the Independent National Officer;
    - National guidance on various aspects of the principles
    - The approach to establishing a support scheme for NHS workers and former NHS workers whose performance is sound who can demonstrate that they are having difficulty finding employment in the NHS as a result of having made protected disclosures
    - National guidance on the approach to training staff in supporting the raising of concerns

7. In addition, in light of the review, the national regulators will consider their aligned approach on *Well-Led organisations* and the *Fit and Proper Persons Test*. They will also consider how best to strengthen guidance relating to these issues, consulting publically where appropriate.

Freedom to Speak Up Guardian Role

8. Sir Robert's report sets out the need for a 'Freedom to Speak Up Guardian' in every local NHS healthcare organisation appointed by the organisation's chief executive to act in a genuinely independent capacity. We believe this role will help to drive progress forward and ensure that light is being shone on all elements of local practice around the reporting of concerns. One model to consider for this would be the inspirational work of a nurse in the Mid Staffordshire NHS Foundation Trust who fulfils this role for part of her time.

9. While it is important to allow the role to develop in response to local needs, we believe that this should be underpinned by a consistent framework across the NHS. In particular, standardised training should be provided to each person taking up the role which equips the person with the relevant skills needed to deal with concerns confidentially and sets out how to handle a concern appropriately. There should also be standardised training on how to record a concern and full details of the action taken. This will ensure that data is held in a uniform way on each concern raised and so provide the Care Quality Commission (CQC) and others with a full picture of the concerns raised and how they have been dealt with. We are also considering whether each of the local Guardian roles should report directly to the Independent National Officer or the Chief Executive of the NHS organisation that they are working in.

Question 2: Do you have any opinions on the appropriate approach to the new local Freedom to Speak Up Guardian role?

Question 3: How should NHS organisations establish the local Freedom to Speak Up Guardian role in an effective, proportionate and affordable manner?

Question 4: If you are responding on behalf of an NHS organisation, how will you implement the role of the Freedom to Speak Up Guardian in an affordable, effective and proportionate manner?

Question 5: What are your views on how training of the local Freedom to Speak Up Guardian role should be taken forward to ensure consistency across NHS organisations?

Question 6: Should the local Freedom to Speak Up Guardian report directly to the Independent National Officer or the Chief Executive of the NHS organisation that they work for?

Title of the local Freedom to Speak Up Guardian

10. It is important that members of staff within NHS organisations are aware of the local Guardian role and who to go to for help. We think that a standardised name for the local Freedom to Speak Up (FTSU) Guardian role, which is used across all NHS organisations, would help ensure that when staff move from organisation to organisation they are aware of who their local FTSU Guardian is. We have suggested the following names for the role:

    - Independent Patient Safety Champion
    - Freedom to Speak Up Guardian
    - Independent Staff Concerns Advocate

Question 7: What is your view on what the local Freedom to Speak Up Guardian should be called?

Independent National Officer

11. Sir Robert's report also calls for the establishment of an Independent National Officer. It sets out that the role should be resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the following functions:

    - Review the handling of concerns raised by NHS workers, and/or the treatment of the person or people who spoke up where there is cause for believing that this has not been in accordance with good practice
    - Advise NHS organisations to take appropriate action where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect
    - Act as a support for Freedom to Speak Up Guardians
    - Provide national leadership on issues relating to raising concerns by NHS workers
    - Offer guidance on good practice about handling concerns
    - Publish reports on its activities.

12. We are proposing that this role will be based within the Care Quality Commission (CQC). We judge that the CQC, with its clear focus on the safety and quality of care, is the natural home for this post. It already has much contact with staff members who wish to raise concerns, and most of these concerns relate directly to the quality and safety of care that CQC regulates. CQC will be able to consider the issues raised directly through the Independent National Officer as part of its inspection of hospital trusts and GP practices. Subject to views in response to this consultation, the Care Quality Commission will report to the Secretary of State for Health on how this will operate in summer 2015, following wider consultation on the Independent National Officer role by CQC and following discussions with Monitor, NHS Trust Development Authority (TDA) and NHS England.

Question 8: Do you agree that the Care Quality Commission is the right national body to host the new role of Independent National Officer, whose functions are set out in principle15 of the Freedom to Speak Up report?

Standards for Professionals

13. We would also like views on whether there should be standardised practice set out in professional codes on how to raise concerns; setting out that firstly a concern should be raised with the line manager, then the Freedom to Speak Up Guardian and finally the Independent National Officer. We think this is necessary to ensure that staff are aware of how to raise concerns and to promote the culture that raising concerns is good practice.

Question 9: Do you agree that there should be standardised practice set out in professional codes on how to raise concerns?

Strengthening legislation

14. Principle 20 of the report and the three related actions cover the issue of whether legal protection should be enhanced. The Government has responded immediately by tabling an amendment to the Small Business, Enterprise and Employment Bill in this Parliament to protect whistleblowers from discrimination by future NHS employers who see them as ‘troublemakers’ rather than the committed professionals that they are. We will consider in more detail the suggestions for inclusion in the list of prescribed persons in the Schedule to the Public Interest Disclosure (Prescribed Persons) Order 2014 and will seek to make legislative change at the next opportunity, where appropriate. We will work with the Department for Business, Innovation and Skills to bring all students working towards a career in health and care into the scope of the definition of worker later in 2015, subject to the parliamentary timetable.

Consultation Questions

Question 1: Do you have any comments on how best the twenty principles and associated actions set out in the Freedom to Speak Up report should be implemented in an effective, proportionate and affordable way, within local NHS healthcare providers?

In considering this question, we would ask you to look at all the principles and actions and to take account of local circumstances and the progress that has already been made in areas highlighted by “Freedom to Speak Up”.

Question 2: Do you have any opinions on the appropriate approach to the new local Freedom to Speak Up Guardian role?

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Question 8: Do you agree that the Care Quality Commission is the right national body to host the new role of Independent National Officer, whose functions are set out in principle15 of the Freedom to Speak up report?

Question 9: Do you agree that there should be standardised practice set out in professional codes on how to raise concerns?

Responding to this consultation - Consultation process

This document launches a consultation on the approach to implementing the recommendations in the Freedom to Speak Up Review.

The consultation is being run, as far as is practical, in accordance with the Cabinet Office Code of Practice on Consultations (reproduced below). The closing date for the consultation is 4 June 2015.

There is a questionnaire on the GOV.UK website which can be printed and sent by post to: Freedom to Speak UP Review, Recommendations:, 2N09, Quarry House, Quarry Hill, Leeds, LS2 7UE

Completed questionnaires can also be sent electronically by e-mail to: HRDlistening@dh.gsi.gov.uk

Alternatively you may also complete the online consultation response document at: http://consultations.dh.gov.uk

It will help us to analyse the responses if respondents fill in the online consultation response document but responses that do not follow the structure of the questionnaire will be considered equally. It would also help if responses were sent in Word format, rather than in pdf format.
Criteria for consultation

This consultation follows the Government Code of Practice, in particular we aim to:

- Formally consult at a stage where there is scope to influence the policy outcome;
- Consult for a sufficient period.
- Be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- Ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- Keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- Analyse responses carefully and give clear feedback to participants following the consultation;
- Ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at: www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

If you have any concerns or comments which you would like to make relating specifically to the consultation process itself please contact:
Consultations Coordinator, Department of Health, 2E08, Quarry House Quarry Hill Leeds LS2 7UE (Please do not send consultation responses to this address).

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter (www.dh.gov.uk/en/FreedomOfInformation/DH_088010).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of consultation responses

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the GOV.UK website (www.gov.uk/dh).

Annex A

Recommendations, principles and actions set out in the Freedom to Speak Up Report.

Recommendation 1: All organisations which provide NHS healthcare and regulators should implement the Principles and Actions in this report, in line with the good practice described in this report.

Recommendation 2: The Secretary of State should review at least annually the progress made in the implement of these Principles and Actions and the performance of the NHS in handling concerns and the treatment of those who raise them, and report to Parliament.

Principles and Actions

Culture Change

Principle 1

Culture of safety: Every organisation involved in providing NHS health care, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.

Action 1.1 Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis.

Action 1.2 System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led.

Principle 2

Culture of raising concerns: Raising concerns should be part of the normal routine business of any well-led NHS organisation.

Action 2.1 Every NHS organisation should have an integrated policy and a common procedure for employees to formally report incidents or raise concerns. In formulating that policy and procedure organisations should have regard to the descriptions of good practice in this report.

Action 2.2 NHS England, NHS TDA and Monitor should produce a standard integrated policy and procedure for reporting incidents and raising concerns to support Action 2.1.

Principle 3

Culture free from bullying: Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.

Action 3.1: Bullying of staff should consistently be considered, and be shown to be, unacceptable. All NHS organisations should be proactive in detecting and changing behaviours which amount, collectively or individually, to bullying or any form of deterrence against reporting incidents and raising concerns; and should have regard to the descriptions of good practice in this report.

Action 3.2 Regulators should consider evidence on the prevalence of bullying in an organisation as a factor in determining whether it is well-led.

Action 3.3 Any evidence that bullying has been condoned or covered up should be taken into consideration when assessing whether someone is a fit and proper person to hold a post at director level in an NHS organisation.

Principle 4

Culture of visible leadership: All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.

Action 4.1 Employers should ensure and be able to demonstrate that staff have open access to senior leaders in order to raise concerns, informally and formally.

Principle 5

Culture of valuing staff: Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.

Action 5.1 Boards should consider and implement ways in which the raising of concerns can be publicly celebrated.

Principle 6

Culture of reflective practice: There should be opportunities for all staff to engage in regular reflection of concerns in their work.

Action 6.1 All NHS organisations should provide the resources, support and facilities to enable staff to engage in reflective practice with their colleagues and their teams.

Better Handling of Cases

Principle 7

Raising and reporting concerns: All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.

Action 7.1 Staff should be encouraged to raise concerns informally and work together with colleagues to find solutions.

Action 7.2 All NHS organisations should have a clear process for recording all formal reports of incidents and concerns, and for sharing that record with the person who reported the matter, in line with the good practice in this report.

Principle 8

Investigations: When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.

Action 8.1 All NHS organisations should devise and implement systems which enable such investigations to be undertaken, where appropriate by external investigators, and have regard to the good practice suggested in this report.

Principle 9

Mediation and dispute resolution: Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.

Action 9.1 All NHS organisations should have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to:

- address unresolved disputes between staff or between staff and management as a result of or associated with a report raising a concern; and;
- repair trust and build constructive relationships.

Measures to support good practice

Principle 10

Training: Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.

Action 10.1 Every NHS organisation should provide training which complies with national standards, based on a curriculum devised jointly by HEE and NHS England in consultation with stakeholders. This should be in accordance with the good practice set out in this report.

Principle 11

Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.

Action 11.1 The Boards of all NHS organisations should ensure that their procedures for raising concerns offer a variety of personnel, internal and external, to support staff who raise concerns including:

a) a person (a 'Freedom to Speak Up Guardian') appointed by the organisation's chief executive to act in a genuinely independent capacity

b) a nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports on concerns raised by staff and the organisation's culture to the Board

c) at least one nominated executive director to receive and handle concerns

d) at least one nominated manager in each department to receive reports of concerns

e) a nominated independent external organisation (such as the Whistleblowing Helpline) whom staff can approach for advice and support.

Action 11.2 All NHS organisations should have access to resources to deploy counselling and other means of addressing stress and reducing the risk of resulting illness after staff have raised a concern.

Action 11.3 NHS England, NHS TDA and Monitor should issue joint guidance setting out the support required for staff who have raised a concern and others involved.

Principle 12

Support to find alternative employment in the NHS: Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.

Action 12.1 NHS England, the NHS Trust Development Authority and Monitor should jointly devise and establish a support scheme for NHS workers and former NHS workers whose performance is sound who can demonstrate that they are having difficulty finding employment in the NHS as result of having made protected disclosures.

Action 12.2 All NHS organisations should actively support a scheme to help current and former NHS workers whose performance is sound to find alternative employment in the NHS.

Principle 13

Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.

Action 13.1 All NHS organisations that are obliged to publish Quality Accounts or equivalent should include in them quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the action taken in respect of them and feedback on the outcome.

Action 13.2 All NHS organisations should be required to report to the National Learning and Reporting System (NLRS), or to the Independent National Officer described in Principle 15, their relevant regulators and their commissioners any formally reported concerns/public interest disclosures or incidences of disputed outcomes to investigations. NLRS or the Independent National Officer should publish regular reports on the performance of organisations with regard to the raising of and acting on public interest concerns; draw out themes that emerge from the reports; and identify good practice.

Action 13.3

a) CEOs should personally review all settlement agreements made in an employment context that contain confidentiality clauses to satisfy themselves that such clauses are genuinely in the public interest.

b) All such Settlement Agreements should be available for inspection by the CQC as part of their assessment of whether an organisation is ‘well-led’

c) If confidentiality clauses are to be included in such settlement agreements for which Treasury approval is required, the trust should be required to demonstrate as part of the approval process that such clauses are in the public interest in that particular case.

d) NHS TDA and Monitor should consider whether their role of reviewing such agreements should be delegated to the Independent National Officer recommended under Principle 15.

Principle 14

Accountability: Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for:

- **poor practice in relation to encouraging the raising of concerns and responding to them;**
- **the victimisation of workers for making public interest disclosures;**
- **raising false concerns in bad faith or for personal benefit;**
- **acting with disrespect or other unreasonable behaviour when raising or responding to concerns;**
- **inappropriate use of confidentiality clauses.**

Action 14.1 Employers should ensure that staff who are responsible for, participate in, or permit such conduct are liable to appropriate and proportionate disciplinary processes.

Action 14.2 Trust Boards, CQC, Monitor and the NHS TDA should have regard to any evidence of responsibility for, participation in or permitting such conduct in any assessment of whether a person is a fit and proper person to hold an appointment as a director or equivalent in accordance with the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 regulation 5.

Action 14.3 All organisations associated with the provision, oversight or regulation of healthcare services should have regard to any evidence of poor conduct in relation to staff who have raised concerns when deciding whether it is appropriate to employ any person to a senior management or leadership position and whether the organisation is well-led.

Principle 15

External Review: There should be an Independent National Officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this Report, namely:

- **review the handling of concerns raised by NHS workers and/or the treatment of the person or people who spoke up, where there is cause for believing that this has not been in accordance with good practice;**

- **advise NHS organisations to take appropriate action where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect;**

- **act as a support for Freedom to Speak Up Guardians;**

- **provide national leadership on issues relating to raising concerns by NHS workers;**

- **offer guidance on good practice about handling concerns;**

- **publish reports on the activities of this office.**

Action 15.1 CQC, Monitor, NHS TDA, and NHS England should consider and consult on how such a post might jointly be created and resourced and submit proposals to the Secretary of State, as to how it might carry out these functions in respect of ongoing and future concerns.

Principle 16

Co-ordinated Regulatory Action: There should be co-ordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.

Action 16.1 CQC, Monitor, NHS TDA in consultation with the Department of Health should work together to agree procedures and define the roles to be played by each in protecting workers who raise concerns in relation to regulated activity. Where necessary they should seek amendment of the regulations to enable this to happen.

Action 16.2 Healthcare professional regulators should review their procedures and processes to ensure compliance with the good practice set out in this report and with this Principle.

Principle 17

Recognition of organisations: CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.

Action 17.1 CQC should consider the good practice set out in this report when assessing how organisations handle staff concerns. Good practice should be viewed as a positive factor contributing to a good or outstanding rating as part of their well- led domain.

Particular measures for vulnerable groups

Principle 18

Students and Trainees: All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.

Action 18.1 Professional regulators and Royal Colleges in conjunction with Health Education England should ensure that all students and trainees working towards a career in healthcare have access to policies, procedure and support compatible with the principles and good practice in this report.

Action 18.2: All training for students and trainees: working towards a career in healthcare should include training on raising and handling concerns.

Principle 19

Primary Care: All principles in this report should apply with necessary adaptations in primary care.

Action 19.1 NHS England should include in its contractual terms for general/ primary medical services standards for empowering and protecting staff to enable them to raise concerns freely, consistent with these Principles

Action 19.2 NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with this report.

Action 19.3 In regulating registered primary care services CQC should have regard to these Principles and the extent to which services comply with them.

Enhancing the legal protection

Principle 20

Legal protection should be enhanced

Action 20.1 The Government should, having regard to the material contained in this report, again review the protection afforded to those who make protected disclosures, with a view to including discrimination in recruitment by employers (other than those to whom the disclosure relates) on grounds of having made that disclosure as a breach of either the Employment Rights Act 1996 or the Equality Act 2010.

Action 20.2 The list of persons prescribed under the Employment Rights Act 1996 should be extended to include all relevant national oversight, commissioning , scrutiny and training bodies including NHS Protect, NHS England, NHS Clinical Commissioning Groups, Public Health England, Healthwatch England, local Healthwatch, Health Education England, Local Education and Training Boards, and the Parliamentary and Health Service Ombudsman.

Action 20.3 The Government should ensure that its proposal to widen the scope of the protection under the Employment Rights Act 1996 includes all students working towards a career in healthcare.