## Purpose

The purpose of this report is to outline the recommendations emerging from the Freedom to Speak Up Review and to highlight where appropriate the nature of any subsequent actions required by the Trust.

### Trust Objectives

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### Executive Summary

The recommendations of the Freedom to Speak Up Review commissioned by the Secretary of State and Chaired by Sir Robert Francis QC, were published on 11th February 2015. The purpose of the review has been to provide independent advice and recommendations on creating a more open and honest reporting culture in the NHS.

The report concludes that there is a culture within many parts of the NHS which deters staff from raising concerns and which often has negative consequences for those who raise them.

The report makes a number of key recommendations under five overarching themes with actions for NHS organisations and professional and system regulators to help foster a culture of safety and learning in which all staff feel safe to raise a concern.

The Government have confirmed that that they intend to accept all of the recommendations in principle and that they will consult on a package of measures to implement them.

As a Trust we already have many of the principles recommended by Francis enshrined in our Raising Concerns Policy. We will take the necessary action to review this in line with the examples of best practice identified in the report and the guidelines to be issued by the Department for Health following the consultation with stakeholders about how best to implement the recommendations.

### Key Recommendations

#### Recommendations

Trust Board members are asked to:

1. **Note and receive the content of this report.**

2. **Request that the revised Raising Concerns Policy and details of the supporting training programme are submitted for approval when complete with updates on progress towards the achievement of this objective being submitted to Governance Committee.**
iii) Formally identify the Medical Director as the Trust’s Executive Lead for raising concerns given his portfolio for Quality and Safety.

iv) Identify a Non –Executive Director to provide oversight and challenge to the Executive Team on areas specific to raising concerns and the culture of the organisation.

v) Determine the process by which the Trust will identify its Freedom to Speak Up Guardian.

vi) Support the establishment of an Executive led panel comprising the Medical Director, Director of Nursing and the Director of HR & OD to review concerns, to make decisions on the appropriate level of action and to report to the Chief Executive.

Assurance Framework
The report provides information on the key risks and current level of assurance in meeting the Trust’s objectives.

Next Steps
Where appropriate these are outlined in the main body of the report.

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| Acronyms / Terms used in Report |
1. Introduction

1.1 The recommendations of the Freedom to Speak Up Review commissioned by the Secretary of State and Chaired by Sir Robert Francis QC, were published on 11th February 2015. The purpose of the review has been to provide independent advice and recommendations on creating a more open and honest reporting culture in the NHS. The review followed on from the Public Enquiry, also Chaired by Sir Robert, into the Mid Staffordshire NHS Foundation Trust which exposed unacceptable levels of patient care and a culture that deterred staff from raising concerns.

1.2 The review was conducted throughout the summer of 2014 and sought a wide range of views from across the NHS – including first hand experiences from staff who had raised a concern (and reported that they had suffered some form of detriment as a result of doing so), employers, professional and system regulators, and other professional bodies. More details about the review and engagement, visit the Freedom to Speak Up website.

In addition NHS Employers, the NHS Confederation and the Foundation Trust Network hosted a round-table meeting on 14 August 2014 with Sir Robert and the Review Team - inviting a number of Chief Executives and Directors from the NHS to give an informed view about some of the complexities employers were often challenged with when staff raised concerns with them.

1.3 The report concludes that there is a culture within many parts of the NHS which deters staff from raising concerns and which often has negative consequences for those who raise them. This is borne out by the results of the latest National NHS Staff Survey which revealed that whilst 93% of staff reported that they know how to raise any concerns they had about unsafe clinical practice within the Acute Trust Sector only 67% of staff reported that they would feel secure doing so.

1.4 At RCHT colleagues have consistently reported being aware of the Trusts Policy on Raising Concerns and therefore how they should go about doing so. This was highlighted as strength by the CQC in the report that followed their inspection in January 2014. Unfortunately our latest staff survey results suggest that colleagues share the reservations of the wider NHS workforce about the implications of raising concerns with only 54% of those who responded agreeing that they would feel secure raising concerns about unsafe clinical practice.

1.5 The report makes a number of key recommendations under five overarching themes with actions for NHS organisations and professional and system regulators to help foster a culture of safety and learning in which all staff feel safe to raise a concern.
These themes are:-

- Cultural Change
- Improved handling of cases
- Measures to support good practice
- Particular measures for vulnerable groups
- Extending legal protection

1.6 The Government have confirmed that that they intend to accept all of the recommendations in principle and that they will consult on a package of measures to implement them. Announcing his acceptance of the report the Secretary of State indicated the Government would talk to Monitor, the Trust Development Authority and NHS England to support whistleblowers and that these bodies have agreed a compact for action on this issue the details of which will be posted later this year.

1.7 The Secretary of State also made a commitment to write to every NHS trust chair to reinforce the importance of staff being able to discuss concerns openly in teams, and for appropriate actions to be taken. He specifically stated that each organisation should act now to appoint a local guardian who has a direct reporting line to the chief executive, who staff can approach to raise concerns.

1.8 News of the report’s publication, together with a link to the report itself was shared with colleagues in the staff bulletin. The supporting article reiterated the commitment of the Trust to having colleagues speak up and raise their concerns as part of normal working life and that they would be supported for doing so.

1.9 The purpose of this report is to outline the recommendations emerging from the Freedom to Speak Up Review and to highlight where appropriate the nature of any subsequent actions required by the Trust.

2. Freedom to Speak Up Review Outcomes

Culture

2.1 The Freedom to Speak Up report recognises that much progress has been made in the NHS since the public inquiry into the failings Mid Staffordshire, and that there is clear evidence that concerns are raised on a daily basis, are listened to, and are addressed and resolved. Steps have been undertaken in a large number of trusts across the country to improve the way in which management responds to concerns. However, the report also provides some pretty hard hitting evidence where this has not been the case.

In particular, the report emphasises a need for a culture of safety and learning in which all staff feel safe to raise a concern and for these conversations to take place as part of everyday practice, without fear of blame or reprisal. Sir Robert identified that there remains a disparity between policies and standardisation of procedures and the level of support given to staff.
The report recognises some of the excellent leadership in some trusts, which should be harnessed and adopted across organisations. To further improve culture, employers are encouraged to celebrate the benefits for patients and the public when concerns are raised. The review also heard many examples of reflective practice and how these are invaluable. Despite pressures on the system, Sir Robert stresses the importance of staff having time to explore issues, analyse systems and share good practice.

2.2 The report concludes that evidence gathered from other sectors where safety is an issue, such as the Oil, Aviation and Nuclear industries reflects that a good safety culture needs time and effort to embed – this is most successful in organisations where responsibility and accountability for local policy and procedures for raising concerns sit with the wider executive team as opposed to Human Resources.

Having a champion, or guardian who has lead responsibility for dealing with concerns raised, is considered key to ensuring policies and practices are robust and staff are appropriately supported, listened to, and issues are resolved quickly and professionally. This does not necessarily entail a member of the board having this responsibility but can be a nominated manager who has authority and autonomy to report directly to the chief executive on the issue of concerns.

The report suggests that for this to work efficiently the postholder needs to have “the right interpersonal skills, courage, tenacity and the respect of colleagues as well as the full confidence of the Chief Executive. The postholder also needs to be pragmatic, fair and understand the structure of his/her organisation and its place in the healthcare system nationally”. The report is silent on how organisations might determine the individual best suited to fulfilling this role.

2.3 The report does however make some very clear recommendations about the role of designated Executive and Non Executive leads with specific responsibility for whistleblowing. The report suggests that organisations may wish to consider having both but that in whatever configuration if should be an oversight role, demonstrating the commitment of the Board as a whole to effective handling of concerns raised by staff.

The report recognises that it would not be practicable for a Non Executive Director to act as a sole point of contact for whistleblowers in an organisation, given the time constraints inherent in the role. However, it would be desirable to use a Non Executive Director’s ability to act as an independent voice and Board level champion for those who raise concerns. The Non Executive Director would work closely with the Freedom to Speak Up Guardian and, like them, could act as a conduit through which information is shared between staff and the Board. The Non Executive Director should be expected to provide challenge alongside the Freedom to Speak Up Guardian to the Executive Team on areas specific to raising concerns and the culture in the organisation.

2.4 The Executive Board lead, or leads, would oversee internal processes and keep them under review, ensure staff felt empowered to raise concerns, ensure learning from concerns was shared across the organisation, and should be accountable for the treatment of whistleblowers within the organisation. They should have the executive responsibility to account to the Board, for the system of handling concerns
and supporting those who raise them. The report suggests that in order to affect a clear distinction between raising concerns in the context of safety and quality and employment/HR procedures and practices responsibility for this should sit not with HR but the Executive responsible for Quality and Safety. At RCHT, this is Dr Rob Parry, Medical Director.

The report suggests that organisations might alternatively choose to nominate a range of directors, to enable staff to go to their professional lead or the leader with direct oversight of a particular area. The report describes an organisation in which a panel of executive directors meets weekly to review all concerns to make decisions on the appropriate level of action and to report to the Chief Executive. It suggests that such arrangements appear to be highly effective. This mirrors the approach taken by the Trust in respect of the oversight of the SI process with a panel comprising the Medical Director, Director of HR & OD, Deputy Director of Nursing and members of the Governance Team meeting weekly to provide challenge, support and scrutiny of SI investigations and the subsequent reports. This system and the corresponding changes to process necessary to support it have been extremely successful in terms of improving both the timeliness and quality of our response to SI’s and the level of divisional engagement with the process. Again, the key is for the Board and Chief Executive to establish arrangements that work both for the organisation and for staff within it to create a culture in which people feel supported.

2.5 The reports also recommends that organisational boards and senior teams adopt and promote a zero tolerance approach to bullying, and for regulators to consider this as a factor when assessing whether an organisation is well-led.

To support this principle, NHS England, Monitor and the NHS Trust Development Authority (TDA) have been asked to produce a standard policy and procedure which will form the basis of any changes required by employers.

Handling Cases

2.6 The report provides clear evidence that in many of the cases presented, much of the pain and expense could have been more easily avoided if concerns had been handled effectively early on. It highlights the importance of organisations investigating concerns raised and ensuring that appropriate feedback is given to the individual(s) raising the concern. This is critical in building staff confidence in local systems and in encouraging others to speak up.

The report Recommends that all organisations should have measures in place which help facilitate informal and formal resolution of concerns raised. It notes that encouraging staff to raise concerns early on, as part of everyday practice will help with some of this e.g. inviting open conversation about what went well and what didn’t go so well as part of any staff briefings, 1:1’s, team meeting etc. and that this dialogue will be key to fostering an open and transparent approach to dealing with some of the issues raised.

2.7 As a Trust we clearly have more work to do in respect of fostering this open communication. Work is already underway to review our Raising Concerns Policy in the light of the report’s recommendations and a key focus of this activity will be this important area. This work will be informed by the guidelines ultimately developed by
Government/Regulatory bodies and best practice identified in the report and elsewhere.

2.8 The report also recommends that chief executives, or other designated officer in organisations, should be involved and have responsibility for regularly reviewing all concerns that have been formally recorded, to ensure local procedures are effective, and to identify areas for improvement.

To support tackling the issue of poor case management, the report recommends the appointment of an Independent National Officer (INO) by the Care Quality Commission (CQC), Monitor, the NHS TDA and NHS England who will have lead responsibility system-wide to look into cases, advise NHS organisations on appropriate action where they have failed to follow good practice, or advise the relevant system regulator to enforce direct action on that organisation, as appropriate, and act as a national support for Freedom to Speak Up guardians.

2.9 The report also identifies a bigger role for system regulators and the need for improved co-ordination in relation to their approach to whistleblowing. In particular, around how they capture information about how organisations handle concerns and in taking the appropriate regulatory action. In addition the report identifies a greater role for professional regulatory bodies in relation to how they record, investigate and handle fitness to practise concerns raised with them.

Measures to support good practice

2.10 While creating the right culture and enabling effective reporting and handling of concerns is essential, the report highlights some major gaps in training for all staff so that they understand the importance of raising concerns and how to raise a concern, and for managers so that they are appropriately equipped and supported to deal with concerns raised with them efficiently and effectively.

In all cases where staff had reported that their experience had been a positive one, they stated that they had received good support from their manager both before and after they had raised concerns with them. The report also highlights the need for organisational and personal accountability when raising and handling concerns, especially in relation to the prevention of bullying or other repercussions that the individual raising the concern may be vulnerable to.

As already alluded to above, the report highlights the benefits of having a champion in the organisation who staff can go to when they have a concern, and who has lead responsibility for ensuring concerns are dealt with appropriately and staff are supported.

2.11 The Government has confirmed that “going forward we will ensure that every member of staff, every NHS Manager and every NHS Leader has proper training in how to raise concerns and how to treat people who raise concerns”. The Secretary of State has confirmed that he wishes training to follow a National Standard based on a curriculum developed jointly by Health Education England and NHS England. Whilst we await confirmation of the expectations in respect of this training the Head of Learning and Development has been asked to proactively consider how we might best accommodate its delivery.
2.12 The report also concludes that giving staff access to mediation, mentoring, advice and counselling can vastly improve the managers ability to nip any issues in the bud, and ensure that the individual raising a concern can return to their original position, or be supported to find alternative employment in the NHS, where it is mutually agreed with the individual that this is the most appropriate thing to do. A contentious parting of the ways can quite easily result in individuals being disadvantaged when applying for a new role without the full facts being known - which is unfair to the individual, and a waste of valuable skills and resources to the NHS. The correct handling of concerns can vastly reduce time, resources and expense where issues are left unresolved and need to go through an employment tribunal.

2.13 As part of our commitment to supporting colleagues to raise concerns we do provide access to mediation and counselling and have established a network of individuals trained to provide independent advice and support. This system has been well received but the scope of the network could be improved and as part of the implementation of our revised Raising Concerns policy the intention is to recruit further individuals with the appointments being supported by a publicity campaign increasing awareness and raising the profile of this key support role.

Measures for vulnerable groups

2.14 The review found that certain groups of staff where particularly vulnerable when raising concerns because of the nature of their term of employment which means that they are less likely to be a fully integrated member of a team, and they may miss out on the same level of induction, training, and communications that permanent members of staff may have around raising concerns.

Although the report specifically makes reference to locums, agency and bank workers being more vulnerable but it is essential that we consider how we engage, communicate and support all workers in their organisation on issues relating to raising concerns. This includes students, volunteers and permanent staff who are required to provide services within the community and within primary care.

2.15 While the evidence gathered as part of the review reflected that the experience of BME groups was broadly the same as other staff, it did highlight that a large number of minority groups felt more vulnerable and excluded, with difficulties quite often being exacerbated by cultural misunderstanding. The research collated as part of our independent Equality Delivery System assessment, reported to the Trust Board in January 2015, suggests that this is not the case at RCHT. However in line with the recommendations that Boards should also be aware of any black and minority ethnic (BME) issues and consider whether they need to take action over and above what is recommended in the Freedom to Speak Up report, this is a matter that we will keep under review as part of our on-going Equality Action Plan.

Extending the legal protection

2.16 Finally the report highlights that while fostering the right kind of culture in the NHS to enable staff to raise concerns has to be the key priority, legal protections for
whistleblowers (in the NHS, and across all other sectors) is not considered to be adequate and should be reviewed.

Accordingly the report makes recommendation for an across-Government review of current legislation to extend protections individuals who raise concerns against discrimination in the workplace either under the Employment Rights Act 1996, or under the Equality Act 2010. It also makes recommendation to further extend the list of prescribed bodies/persons under the Public Interest Disclosure Act (PIDA) to include NHS England, Clinical Commissioning Groups (CCGs) and Local Education and Training Boards (LETBs).

3. Conclusion

3.1 As indicated the Government has confirmed that the final decision about how the recommendations are to be implemented will be made after full consultation with both NHS Providers and whistleblowers/patient groups. This is to ensure that the spirit of the recommendations are honoured and that unnecessary layers of bureaucracy or financial burden are avoided. The Secretary of State suggested however that this should not prevent Trusts form considering their position and taking immediate action in respect of the identification of an independent person that staff may raise concerns with.

3.2 As a Trust we already have many of the principles recommended by Francis enshrined in our Raising Concerns Policy. We will take the necessary action to review this in line with the examples of best practice identified in the report and the guidelines to be issued by the Department for Health following the consultation with stakeholders about how best to implement the recommendations.

3.3 As with most Trusts we have not previously run any co-ordinated programme of training for staff and managers in respect of raising concerns, responding to, investigating and feeding back about concerns that are raised or supporting staff when they do. Plans will be developed to introduce such a programme as soon as the curriculum guidelines are available.

3.4 Ultimately however the report recognises that the focus must be on cultural change with very clear messages about the key role Boards must play in ensuring that progress in creating and maintaining a culture of safety and quality is monitored, measured and reported. To that end the identification of our own Freedom to Speak Up Guardian will be crucial as will the support provided to the Guardian by the Executive and Non-Executive Leads.

4. Recommendations

4.1 Trust Board members are asked to:-

   i) Note and receive the content of this report;

   ii) Request that the revised Raising Concerns Policy and details of the supporting training programme are submitted for approval when complete with updates on progress towards the achievement of this objective being submitted to Governance Committee;
iii) Formally identify the Medical Director as the Trust’s Executive Lead for raising concerns given his portfolio for Quality and Safety;

iv) Identify a Non-Executive Director to provide oversight and challenge to the Executive Team on areas specific to raising concerns and the culture of the organisation;

v) Determine the process by which the Trust will identify its Freedom to Speak Up Guardian;

vi) Support the establishment of an Executive led panel comprising the Medical Director, Director of Nursing and the Director of HR & OD to review concerns, to make decisions on the appropriate level of action and to report to the Chief Executive.