

A review by the  
National Guardian of  
speaking up in an NHS  
trust

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# Executive summary

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The National Guardian's Office has conducted a review of the speaking up processes, policies and culture at Royal Cornwall Hospitals NHS Trust, in response to information the office received that the trust's response to the concerns raised by its workers was not in accordance with good practice.

The purpose of the review was to look at the trust's speaking up policies and procedures, as well as how it had handled individual speaking up cases raised by its workers, to identify any learning to improve the trust's speaking up culture.

We also wanted to highlight any good examples of speaking up practice in the trust so that these may be followed by other trusts in England.

The trust supported the review through arranging interviews and meetings with many of its workers and leaders.

The review found evidence that the trust did not always respond to instances of its workers speaking up in accordance with its policies and procedures, or with good practice. Such responses contributed to a belief among some of the workers who spoke to our review that there was not a positive speaking up culture in the trust and that the issues that they raised were either poorly handled, or ignored by management.

Our review also identified areas where the trust could do more to support the speaking up culture. While the trust commissioned speaking up training for its workers, the training did not refer to national guidance on good speaking up practice issued by either the National Guardian's Office, or NHS Improvement.

In addition, there was evidence that settlement agreements between the trust and workers were difficult to understand and gave workers the impression that they were not free to speak up.

More positively, it was clear that the leadership of the trust understood well the need to improve the speaking up culture, and were beginning to take steps to do this. These included providing workers with a variety of means of raising issues through a network of speaking up champions across the trust, who supported the work of the trust Freedom to Speak Up Guardian.

The trust leadership also expressed a commitment to make the settlement agreements it reached with its workers more supportive of speaking up.

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## Our findings can be summarised as follows:

There were areas where the trust leadership needed to do more to improve the speaking up culture for its workers:

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- Evidence that senior staff did not always respond to workers who spoke up in a manner that was consistent with the trust's speaking up policy, or in accordance with general principles of good speaking up practice
  - Staff who spoke up did not always receive feedback on the outcome of concerns raised
  - Evidence that staff in some parts of the trust feared they would receive 'retaliation' for speaking up
  - Evidence that relations between staff in several parts of the trust was poor and were characterised by a grievance culture, often arising from historic issues between workers that had not been resolved
  - Although the trust had commissioned speaking up training for its Freedom to Speak Up Champions to help ensure they properly handled issues raised by workers this training did not make appropriate reference to guidance on speaking up good practice issued by the National Guardian's Office or NHS Improvement
  - Evidence that settlement agreements between the trust and workers who had left their posts presented a barrier to speaking up and potentially to staff receiving support
  - The trust did not have a conflicts of interest policy. This was not in accordance with national guidance from NHS England.

There were also examples of where the trust was taking active steps to support speaking up. These included:

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- Ring-fenced time for the trust Guardian to ensure their availability to support workers
  - Appointing a network of speaking up champions to support the work of the trust Freedom to Speak Up Guardian and to help ensure that staff working across a geographically wide area had access to support to raise issues
  - Gap analysis undertaken by the trust in relation to learning identified in other case review reports from the National Guardian's Office to determine how the trust could apply that learning to improve its own speaking up arrangements

## Acknowledgements and thanks

The completion of our review has been made possible only because of the support and contributions from the following individuals and organisations:

- 
- Trust workers who have told us about their experiences of speaking up
  - The leaders of the trust
  - The trust's Freedom to Speak Up Guardian and champions
  - NHS Improvement
  - Care Quality Commission
  - The Department of Health and Social Care
  - NHS Employers

# Introduction

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## The National Guardian's Office

The National Guardian's Office (NGO) provides leadership, support and guidance on speaking up in the NHS, and was set up in response to recommendations made in Sir Robert Francis' 'Freedom to Speak Up' review, published in 2015<sup>1</sup>.

The review set out 20 principles and actions to enable NHS workers to speak up freely at work, without fear of detriment, and to ensure that their concerns are responded to appropriately. These principles are designed to create a safer and more effective service for everyone.

The office began its work in April 2016. This principally involves support, training and guidance for a network of Freedom to Speak Up Guardians across the NHS, whose function is to provide independent support for workers to raise issues in the workplace. The office also undertakes reviews of the speaking up arrangements in NHS trusts, including how individual cases have been handled, where it receives evidence that workers have not been appropriately supported to speak up.

The NGO is an operationally independent body funded by NHS Improvement, NHS England and the Care Quality Commission.

More information about the work of the National Guardian's Office is [available here](#).

## Case reviews by the NGO

As part of its work the NGO reviews how a NHS trust has supported its workers to speak up, where it receives evidence that this support may not have met with good practice.

The standards of good practice against which the NGO assess the actions of trusts are found in a variety of sources, including the Francis Freedom to Speak Up review and the speaking up guidance for trust boards, published jointly by NHS Improvement and the National Guardian's Office in May 2018<sup>2</sup>.

The dual roles of case reviews are to listen to individuals and to identify learning about how speaking up practices may be improved, not just in the trust where the review takes place, but across the whole NHS, including bodies responsible for supporting the system.

In addition to recommending improvements, the reviews also seek to identify examples of good speaking up practice.

To promote this shared learning, the guidance for boards described above includes a recommendation that all trusts adopt, where appropriate, the recommendations for improvement identified in each speaking up review.

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<sup>1</sup> [http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU\\_web.pdf](http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf)

<sup>2</sup> [https://improvement.nhs.uk/documents/2468/Freedom\\_to\\_speak\\_up\\_guidance\\_May2018.pdf](https://improvement.nhs.uk/documents/2468/Freedom_to_speak_up_guidance_May2018.pdf)

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The NGO works with the trust in question to identify relevant information and to feedback learning as it arises.

The NGO operates independently. It works closely with the regulators that fund it and shares the findings of its case reviews with them to help ensure NHS trusts receive all appropriate support to improve their speaking up culture, processes and policies.

Care Quality Commission inspectors review evidence relating to speaking up cultures and arrangements as part of their assessment of how well a trust is led.

## Why we conducted a case review at Royal Cornwall Hospitals NHS Trust

The NGO initially received information that the response of the trust to a speaking up issue raised by one of its workers was not in accordance with good practice. Because the information indicated that significant learning could be obtained from reviewing the case the office decided to review how the trust had handled the case.

As well as considering the information received in the original referral, the NGO looked at other available data about the trust, including its 2017 NHS staff survey, to determine whether learning could be obtained from reviewing the speaking up culture, across the whole trust.

As this information indicated this was the case, the office decided to undertake a broad review of the speaking arrangements at the trust, as well as a review of the case first referred to it.

Following the announcement of our review, we received information relating to further examples of potential poor handling of individual speaking up cases, which we then also reviewed and have commented upon in this report.

## How we conducted our review

In May 2018 we visited the three principal sites in the trust, namely Royal Cornwall Hospital in Truro, St. Michael's Hospital in Hayle and West Cornwall in Penzance.

Across those three locations we met with a total of 34 members of staff, including clinicians, managers and ancillary staff, as well as the trust chief executive officer, board members and the Freedom to Speak Up Guardian and champions.

We held a total of four staff forums across all sites to encourage as many workers as possible to tell us about their experiences of speaking up in the trust, to gain an insight into the culture, to identify examples of good practice and where we could support the trust to improve. These forums were actively promoted by the trust to enable workers to share their experiences.

As well as meeting with staff, we reviewed a range of documents relating to speaking up in the trust, including trust policies, procedures and strategies, as well as staff surveys.

In addition to forums and one to one meetings, trust workers were also able to contact NGO staff directly.

In addition, we asked other bodies to share what they knew about the trust's support for speaking up, including the Care Quality Commission and NHS Improvement.

Where we found issues we immediately raised them with the trust to allow them to address them as quickly as possible.

We worked jointly with the trust to undertake the review, including collaborating on joint communications. We want to thank the trust for its positive and supportive response to the review process at every stage.

## Recommendations and actions

In response to the learning we identified, we have made 13 recommendations for the trust relating to the actions they need to take to improve their support for their workers to speak up.

We have also made two recommendations for ourselves; to provide national guidelines concerning the content of speaking up training provided by NHS trusts for their workers and on settlement agreements.

Each of our recommendations carries a time frame by which we expect them to be implemented. NHS Improvement, which is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care, will ask trust leaders to provide them with a plan summarising these actions within 28 days of the publication of this report. The NGO will also provide NHS Improvement with an action plan to address the training recommendation it has made for itself.

These actions will in all cases include measures to determine their effectiveness.

Representatives from NHS Improvement will meet with the trust and the NGO at regular intervals to review the implementation of their respective action plans.

## The good practice we found – based on the principles from the 2018 Freedom to Speak Up Guardian Survey

We identified examples of good speaking up practice in the trust as a whole, based on the principles of good practice that we set out in our survey of Freedom to Speak Up Guardians in 2018.

A link to this survey can be [found here](#).

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- **Fairness** - The Freedom to Speak Up Guardian was appointed through an open recruitment process
- **Reach** - The appointment of a Freedom to Speak Up Guardian with ring-fenced time and 10 Freedom to Speak Up champions to help enable workers to receive support to speak up across the wide geography of the trust and its multiple locations and services
- **Leadership** - Staff working as part of the trust's freedom to speak up arrangements demonstrated a commitment to supporting workers to speak up and a willingness to improve the trust's speaking up culture
- **Openness** - The Freedom to Speak Up Guardian presented regular reports to the trust board in person that summarised their work in supporting workers to speak up, including data summaries, analysis and recommendations for action
- **Feedback** – The Guardian regularly sought feedback from the workers they had supported to speak up to help identify how they could continually develop and improve their performance
- **Time** – Ring-fenced time for the Guardian helped ensure that their time to support workers was protected

## The structure of this report

26 workers approached our review team during our visits to the trust to describe their experiences of speaking up and gave their consent for us to look into how their cases had been handled. Because there were common themes relating to how their cases were handled we have grouped those cases under those themes. The learning we have identified is set out beneath each theme.

As with all our case reviews, we take all reasonable steps to ensure that we do not reveal individual workers' identities, regardless of their position in the trust. This is because the focus of our reviews is on learning, not blaming.

The only individual we identify in this report is the trust Freedom to Speak up Guardian. This is because it would not be possible to describe accurately the speaking up arrangements in the trust without making reference to them.

We have discussed the learning we have identified regarding those services with the trust's leaders. Wherever they have committed to take action to address that learning we have reported this.

Where we have quoted individuals or organisations we have indicated this through the use of inverted commas and speech marks.

## About the trust

The trust website states<sup>3</sup> 'The Royal Cornwall Hospitals NHS Trust is the main provider of acute and specialist care services in Cornwall and the Isles of Scilly. It serves a population of around 430,000 people, a figure that can increase significantly with visitors during the busiest times of the year. The Trust employs approximately 5,000 staff and has a budget of approximately £380 million.'

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<sup>3</sup> <https://www.royalcornwall.nhs.uk/our-organisation/about/>



## Published information about speaking up in the trust

### **NHS England annual Staff Survey<sup>4</sup>**

All NHS trusts are required to participate in the NHS England staff survey. Its purpose is to collect staff views about working in their NHS organisation to help trusts improve working conditions for staff and patient care.

We looked at relevant results from the trust survey from 2017 and compared these results with those from the 2016 trust survey. (The results from the 2018 NHS Staff Survey are published early in 2019.)

2860 staff took part in the survey, which represented a response rate of 56%. The full results of the survey can be [found here](#).

Three key findings in the survey particularly relate to staff responses regarding a trust's speaking up culture. The first of these relates to whether staff thought the trust's procedures for reporting near misses, errors and incidents were 'fair and effective'. When compared with NHS trusts providing similar services to Royal Cornwall trust the result was in the bottom 20% of all like trusts for that key finding. This result was also the same for that key finding in the trust's 2016 survey.

The second key finding in respect of speaking up related to whether staff felt 'confidence and security' when reporting unsafe clinical practice. Again, when compared to like NHS trusts the result placed Royal Cornwall in the bottom 20% of all like trusts for that key finding.

The third key finding related to what workers said about whether they had experienced harassment, bullying or abuse from other staff in the past 12 months. The findings showed that the trust was worse than other like trusts, although the number of Royal Cornwall staff reporting such experiences was fewer than in the 2016 staff survey.

### **Care Quality Commission (CQC) Inspection**

Inspectors from the CQC last undertook a comprehensive inspection of the services in the trust in September 2018. Overall, they rated the trust as 'requires improvement.' This compared with an overall rating of 'Inadequate' when the CQC previously conducted a comprehensive inspection in the trust in July 2017.

As part of their evaluation of how well a trust is led, inspectors looked at the trust's culture, including its processes to support speaking up. Inspectors gave a rating of 'inadequate' for how well led the trust was.

The full CQC inspection report can be [found here](#).

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<sup>4</sup> <http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2018/>

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# Our findings

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To reach our findings, we met with 34 trust workers, either in one to one interviews or in staff forums, to learn about their experiences of speaking up. We also looked at a range of documents relating to the trust's speaking up arrangements, including its speaking up policy.

From those workers we spoke to 18 workers who believed they had faced obstacles to speaking up gave their consent for us to discuss their experiences of doing so with trust leaders.

Following our review of the trust's speaking up arrangements and of individual cases, we have summarised our findings below.

The speaking up issues the trust workers told us about took place over a four year period dating back from the time of our review.

Firstly, we have set out our findings in relation to workers' individual experiences of speaking up, under sub-headings that reflect obstacles to speaking up that were common to those individual cases. In all the cases described, the workers concerned gave their consent for us to discuss their cases with trust leaders, so that we could obtain a balanced view of what had occurred.

We have taken every reasonable step to protect the identity of individuals.

Secondly, we set out our findings relating to the speaking up arrangements across the whole trust.

Under each sub-heading we provide a recommendation on how support for workers to speak up can be improved. Most recommendations are for actions to be taken by the trust. There are also two recommendations for the National Guardian's Office.

As per NHS Improvement's board guidance, we expect all NHS trusts and foundation trusts to examine the recommendations we make in our case review reports and apply the learning from them where appropriate to their own organisation.

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## A. Findings from themes arising from workers' experiences

### 1. Poor staff relationships

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Of the 34 workers we spoke to, many from across all three main trust locations described a working environment characterised by relationships between staff members that had broken down, often over a long period of time.

The causes of the common breakdown of working relationships were not clear from the information we gathered during our review, although the symptom of such difficulties was evident in how often staff told us that they had brought grievances about the conduct of their colleagues.

We discuss the use of a grievance process within a speaking up culture further below.

The reasons staff gave for the existence of poor working relationships often referred to the working culture in the trust, including the speaking up culture, which we describe below.

Several also cited what they regarded as inappropriate recruitment practices as a cause of poor staff relations, describing their belief that individuals were appointed and promoted based on their close relationships with trust colleagues, rather than as a result of an open and fair recruitment process. The trust acknowledged that in certain circumstances in the past this had occurred but that they are taking steps to address this.

The National Guardian's Office has recently highlighted<sup>5</sup> the need for trusts to support open and honest working cultures by ensuring that personal relationships between staff, especially those with responsibility for decision making, are openly declared, in accordance guidance for trusts relating to conflicts of interest published by NHS England.<sup>6</sup>

However, the trust had no policy to address conflicts of interest, save for in relation to board members, nor were trust leaders aware of the national guidance.

Workers also highlighted the geographical location of the trust as a factor in poor staff relations, stating that because of the trust's relative isolation staff often stayed in their roles for many years and where they remained so did the poor relations between them. One senior leader commented "Many [staff] have a long length of service, they don't go elsewhere. Their views become entrenched."

Nevertheless, what was not clear from our review was why the poor staff relationships that were often so evident were not resolved. When we asked trust leaders about this they could not give a clear explanation, but said that they planned to use mediation more frequently in the trust as a method for resolving issues between workers.

They were also receptive to our suggestion of considering mediation between groups of staff to resolve historic disputes, where there was support and consent from the workers concerned to do this.

We therefore recommend that the trust takes steps to address the problem of poor relationships as described to us by many of the workers who spoke to us across many of its services, firstly by seeking to identify their cause, and then taking appropriate action to address those causes.

We also recommend that the trust takes steps to implement the guidance on managing conflicts of interest from NHS England.

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<sup>5</sup> <https://www.cqc.org.uk/sites/default/files/201801107-Nottinghamshire%20Healthcare%20NHS%20Foundation%20Trust%20A%20review%20of%20the%20handling%20of%20speaking%20up%20cases.pdf>

<sup>6</sup> <https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/>

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## Recommendation 1

**Within 12 months the trust takes appropriate measures to identify the causes of poor working relationships across the whole organisation and implements effective actions to remedy those causes, including steps to measure the effectiveness of those actions.**

## Recommendation 2

**Within 12 months the trust takes steps to implement national guidance from NHS England relating to the managing of conflicts of interest.**

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## 2. Speaking up culture

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As described above, the results for the trust in the 2017 NHS England staff survey were in the bottom 20% percent relating to whether workers felt procedures for reporting near misses, errors and incidents were 'fair and effective' and whether they had 'confidence and security' when reporting unsafe clinical practice.

We asked the workers that we met, at all levels in the organisation across the three main locations of the trust, their view of the speaking up culture in the organisation. Almost all the answers we recorded were negative.

Workers described a culture that was highly unsupportive, where staff did not feel free to speak up, who were ignored when raising matters, told not to speak up at all, or whose issues were not handled in accordance with trust policy, procedures or good practice.

One worker told us that staff where they worked 'got into trouble' for raising concerns. Another, working in a different service said, 'if you do speak up middle management will block you'. Two workers from one service commented 'nobody has acknowledged our difficulty or concerns, and we won't speak up again'.

These experiences go against the principles established in the Francis Freedom to Speak Up review that workers should be thanked and listened to, that their concerns should be investigated and that they should not be victimised because of speaking up.<sup>7</sup>

Several staff from different services also commented that there was a culture of managers telling workers not to raise and record issues using the trust electronic incident reporting system. These staff members said they believed this culture created risks to patient safety. We reported these concerns to both trust leaders and regulators.

Staff comments often referred to a historic poor speaking up culture across the trust. One senior leader told us 'There's a long and dark history to this trust, and to Cornwall generally. Getting through to people is labour intensive. Getting through to them to believe that they will really be listened to and taken seriously has been the most difficult of anywhere I have seen.'

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<sup>7</sup> [http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU\\_web.pdf](http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf)

As described above, there was also evidence that a common response to workers who raised issues was the suggestion that they use the grievance process to resolve the matter. This included when the matter raised was not reasonably a grievance, suggesting that the managers were not taking ownership of the issues.

The frequency with which grievance cases were brought was commented upon by one senior trust leader, who told us “I have never been in a trust where grievances are used as much, even referrals to professional bodies.”

As commented upon in a previous case review from the National Guardian's Office<sup>8</sup>, there are alternatives to grievance processes, which may better support workers' needs due to the often-adversarial nature of the grievance process.

In one example of the use of the process a worker told us that, having raised a series of issues via a grievance, the trust then investigated their concerns, found in their favour, before then offering them the opportunity to bring a further grievance as a remedy to those issues.

Inappropriate use of the grievance process to respond to workers who raise issues neither supports their needs, nor a positive speaking up culture.

Trusts should therefore ensure that workers are aware of all possible routes available to them to speak up and we expect all trusts, including Royal Cornwall to implement the recommendation we made in the case review referred to above.

The positive comments regarding the speaking up culture came in relation to the role of the trust's Freedom to Speak Up Guardian, described below. One worker who received support from the Guardian told us ‘I felt for the first time that someone was actually listening.’

We discussed the trust's speaking up culture with its senior leaders, who acknowledged that it needed significant improvement.

At the time of our review the trust did not yet have a planned response to this issue. We therefore recommend that it undertakes its own work to assess the culture that operates across its workforce, to gain insight into the steps it needs to take to improve that culture. It should then take steps to address the issues it identifies.

As with our comments relating to staff relationships above, we recommend the trust works closely with NHS Improvement in addressing the cultural issues it faces.

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<sup>8</sup> [https://www.cqc.org.uk/sites/default/files/20180620\\_ngo\\_derbyshirecommunityhealthservices\\_nhsft-case\\_review\\_speaking\\_up\\_processes\\_policies\\_culture.pdf](https://www.cqc.org.uk/sites/default/files/20180620_ngo_derbyshirecommunityhealthservices_nhsft-case_review_speaking_up_processes_policies_culture.pdf)

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### Recommendation 3

**Within 12 months trust leaders develop and begin the implementation of a strategy to improve the speaking up culture across its workforce. The plan should contain measures to identify the main issues the trust should address, clear actions to address those issues and steps to measure the effectiveness of those actions.**

### Recommendation 4

**Within 6 months the trust should review incident reporting rates and identify any areas which appear to be under-reporting and take action to address this.**

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## **3. Issues raised by workers not handled with suitable independence**

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We asked for the trust's comments on each of the case studies set out below on how they had responded to workers' speaking up. The trust were able to provide some information in this regard, however, this information was not available in all cases. Where it was provided this is reflected in the case studies.

The case studies set out below describe events that have occurred over a four year time period dating back from the time of our review.

## Background

The trust speaking up policy states that matters raised by workers will be investigated 'using someone suitably independent (usually from a different part of the organisation)'. The first two case studies below describe experiences of speaking up shared with our review where the workers who spoke up believe this did not happen.

## Case study 1

A worker told us that they believed their colleague had neglected patients. The worker told us that they reported this using the trust's electronic incident reporting system. The electronic reporting system was not set up to provide feedback automatically.

The worker received written feedback several weeks after raising the incident. This did not meet their expectations. We have not received a response from the trust as to whether this was within accepted timescales.

The feedback said that the matter had been looked into, and it was concluded that the alleged neglect did not happen. The feedback they received did not say who had carried out the investigation.

The worker approached their manager to discuss this feedback. The worker was shocked to find out that their manager had passed their initial electronic report to the colleague they had alleged neglected patients to investigate their own conduct.

The worker was not aware of any other investigation into the concerns they had raised.

This is an example of practice which is against the principle of fair independent investigations as described by the Francis report.

## Case study 2

A worker told us that they were worried about speaking up about a colleague who had allegedly sexually assaulted<sup>9</sup> them because this colleague was in a relationship with the worker's manager.

The worker said that despite their concern about retaliation, they spoke up about this issue and other issues including patient safety matters. The worker said that following this their manager became verbally hostile towards them. The worker said that subsequently they themselves faced what they regarded as 'trumped up' allegations.

The worker said that their manager initially tasked their self with investigating these allegations, even though, the worker argued, the manager was conflicted because of their relationship with the colleague who the worker claimed had sexually assaulted them.

The worker said that with the support of their union, they made a case against the manager's role in this investigation. The worker said that their manager eventually put someone else in charge of investigating the case.

Independence and timeliness of investigations are key recommendations from the Francis Freedom to Speak Up review.

## Learning and recommendations

On the basis of the information provided by the workers in the first two cases, the trust was in breach of its own policy. Individuals alleged to have acted improperly, or who are closely related to those against who such allegations are made, should clearly not investigate those matters, themselves or other matters where potential conflicts of loyalty exist.

The need to ensure suitably independent investigations in response to workers who speak up has been previously highlighted by a NGO case review.<sup>10</sup>

The failure to appoint suitably independent and trained investigators to respond to matters raised by staff not only creates the risk that necessary learning will not be identified, but also that workers

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<sup>9</sup> The incident was the subject of a police investigation.

<sup>10</sup> [https://www.cqc.org.uk/sites/default/files/20180620\\_ngo\\_derbyshirecommunityhealthservices\\_nhsft-case\\_review\\_speaking\\_up\\_processes\\_policies\\_culture.pdf](https://www.cqc.org.uk/sites/default/files/20180620_ngo_derbyshirecommunityhealthservices_nhsft-case_review_speaking_up_processes_policies_culture.pdf)

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will feel unsupported, believe the trust is not taking their concerns seriously and so undermine the whole speaking up culture in the organisation and the public trust in the NHS.

## Recommendation 5

**Within 3 months the trust should take appropriate steps to ensure that its response to workers speaking up, including the investigations of those issues and the implementation of learning resulting from them, is undertaken by suitably independent trained investigators.**

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## 4. Breach of confidentiality

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### Background

It is an important aspect of good speaking up practice that the confidentiality of those who raise issues should be protected, where they indicate they wish this to happen. The trust speaking up policy clearly demonstrated a commitment to support this.

The case study below describes a worker's experience where they believed this did not happen.

### Case study 3

A worker told us that they spoke up to a manager after witnessing a colleague handling medication in breach of the trust's relevant policies and procedures. The worker said that the manager assured them that they would escalate the concern and that it would be dealt with confidentially.

The worker explained they found out shortly after that the same manager had discussed the concern they had raised with the colleague they had spoken up about without maintaining their confidentiality. Later, the worker also became aware that other staff members had been told that they had spoken up about the medicines issue.

The worker was then informed by their manager that although their colleague admitted the allegation, they also regarded the worker speaking up about them as malicious.

No other action was taken to investigate the concern the worker had raised.

We asked the trust about how they had responded to the worker's speaking up in this case. A trust representative explained that a senior trust leader had been in touch with the worker to thank them for speaking up and reassure them that they had done the right thing by raising this issue. The worker told us that they were nonetheless disappointed with the outcome of the case because the senior leader had told them that they were satisfied with the response to the worker's speaking up.



## Recommendation 6

**Within 3 months the trust should take appropriate steps to ensure that the confidentiality of workers who speak up is appropriately supported, in accordance with trust policy and procedure and good practice.**

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## 5. Failure to respond to speaking up

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### Case study 4

A worker told us that they and their colleagues spoke up about bullying and harassment in their department. The worker explained that in response to this a staff survey was undertaken which found several issues in the department, including a management style which could be interpreted as bullying. The worker explained that an action plan was produced to respond to the survey findings.

However, the worker told us that a senior colleague who it was alleged was partly responsible for the issues highlighted in the survey was tasked with implementing the action plan. The worker said this individual had not acknowledged that they had personally ever bullied staff, or showed any insight into these issues and therefore were not suitable to implement the plan. The worker explained that ultimately nothing came of the action plan.

### Case study 5

A worker told our review they had experienced prolonged bullying and harassment by senior colleagues in their department. They said they had spoken up about this issue on several occasions, but nothing was done about it. The worker said that this caused them great stress, which eventually led to them resigning from the organisation.

### Case study 6

A worker told us of concerns they raised relating to standards of care and patient safety. The worker explained that, in response, their senior colleagues became 'defensive' and blamed the worker for causing the issues that the worker had spoken up about.

The worker said they were also criticised by their colleagues for speaking up about 'too many' issues. Because of this criticism the worker said they sometimes chose not to report issues.

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## Case study 7

A worker who had subsequently left the trust told us that they had spoken up many times throughout the organisation regarding patient safety and other concerns. The worker said that they were 'shouted at and threatened' by their manager for speaking up. As a result, the member of staff explained that they resigned.

The worker explained that they insisted on an exit interview so that they had an opportunity to explain why they had resigned. However, the worker said that the manager carrying out the interview was not interested in what they had to say.

## Case study 8

Workers told us that they were concerned about breaches of the trust's recruitment and secondment policies. They told us that over a long period of time individuals were regularly being appointed to roles without a competitive recruitment process.

Workers told us that attempts to speak up about this within their department were not treated seriously or were met with denial. The workers told us that they escalated their concerns to senior leaders in the trust. However, the first time they did this they were ignored and the practices continued.

The workers said that they then put in an informal grievance with another senior leader detailing their concerns about recruitment practices in their department. However, the workers said that their confidentiality was breached because their manager was informed about the grievance. The workers added that the senior leader assigned to look into their grievance failed to reply to their concerns.

After several weeks, the workers escalated the matters again to a more senior leader who investigated their concerns and ultimately upheld all their grievances. In all, the grievance took nearly seven months to be dealt with by the trust which the workers described as very stressful.

## Learning and recommendations

The experiences of workers in these case studies, as well as what we heard from other workers during our review, showed that there was a real perception among some workers in the trust that there is often a failure to act when workers speak up in the trust.

This belief that speaking up is futile because it will not result in improvement was so entrenched among some workers that we heard of workers who questioned the point of talking about their experiences to the NGO.

In case studies 5 and 7, this poor response to workers speaking up resulted in the workers resigning. In case study 6, the failure to respond appropriately to concerns and even to confront the worker speaking up for raising 'too many' issues resulted in the worker deciding not to speak up in the future.

The failure to act to address the issues raised in the instances of speaking up described in these case studies was in breach of the trust's speaking up policy that states that the trust is committed to *'listening to our staff, learning lessons and improving patient care'*.

Failing to act also potentially represents a failure of insight and a loss of opportunity to learn. Workers are the eyes and ears of an organisation and are often first to identify actual or latent issues that could impact on an organisation's ability to deliver its objectives. A positive speaking up culture recognises the contribution that workers can make to improving the quality of care it delivers.

The cases described above highlight the need for the trust to ensure that it responds appropriately to its workers who speak up, in full accordance with its policies and procedures. Its speaking up policy states: 'In accordance with our duty of candour, our senior leaders and entire board are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need.'

## Recommendation 7

**Within 3 months the trust should ensure that it responds to the issues raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice.**

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## 6. Detriment caused to staff who speak up

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### Background

Ensuring that workers who speak up are protected from detriment for doing so is a key element in a positive speaking up culture and a key recommendation from the Francis Freedom to Speak Up Review.

### Case study 9

A worker told us that after raising issues about patient safety including low staffing levels they were bullied by their senior colleagues as well as their manager who had verbally assaulted them.

The worker perceived that disciplinary proceedings were then brought against them based on false allegations, which led to their dismissal. The worker believed that these actions were motivated by the fact that they had been speaking up about standards of care and patient safety.

Following their dismissal, the worker was referred to their professional body, which launched its own investigation into the worker's conduct. The worker perceived that this was a malicious referral.

We asked the trust to comment on how they had responded to the worker's speaking up, but they did not provide specific information on this point.

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## Case study 10

A worker told us that they had concerns regarding the speaking up culture in their team. They explained that the team manager would respond defensively when colleagues spoke up about patient safety and other issues. Those who spoke up would subsequently face 'concocted' allegations and the threat of disciplinary action. The worker explained that this created a 'culture of fear' in the team and resulted in colleagues leaving the trust.

The worker explained that frequent and prolonged attempts to escalate concerns above local management eventually resulted in a review of the team. This review made a number of recommendations to improve the functioning of the team, including workshops.

The worker explained that the team manager whose behaviour caused concern for many colleagues was either leading or attending these workshops. The worker said that this meant that many colleagues were reluctant to speak openly at these events. The worker said that according to their perception this manager did not display insight and their behaviour had not changed.

The worker claimed that, over a year after the review, the speaking up culture in their team had not improved. The worker said that they approached this manager to express their concern about the lack of improvement in their team. However, the worker added that the manager was frustrated by their speaking up and threatened to put in a grievance against the worker. Fearing that they would face retaliatory allegations, the worker resigned and left the trust.

We asked the trust to comment on how they had responded to the worker's speaking up but they did not provide specific information on this point. However, a trust representative told us that they have taken active steps to improve the speaking up policies and practices in the service where the worker was employed. In particular, the trust representative told us that staff engagement has improved.

## Learning and recommendations

The trust's speaking up policy seeks to assure trust workers that retaliation for speaking up is against the trust's values and that it will not be tolerated. It states:

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*'If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action'*

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We note the assurances provided by the trust's policy on this matter. However, Case Studies 9 and 10, as well as other accounts we heard from trust workers, show that there is a perception among some of them that speaking up could and sometimes does result in retaliatory action in the trust.

The consequences of such alleged retaliation for the individual who has spoken up is apparent. We have heard from several individuals who claimed that they were either dismissed or felt they had no option but to resign because they had spoken up. Many trust workers also told us about the devastating impact that speaking up had on their relationships, career and health.

However, it is not just those individuals who claim to have been victimised when speaking up who suffer. This can also harm the services they work for when their employment ends because of these issues.

Similarly, if workers feel unable to speak up because they fear the consequences, this also puts patient safety at risk.

The speaking up data submitted by the trust shows that 43 cases were brought to the Freedom to Speak Up Guardian over a 12-month period between April 2017 and March 2018 and that in 2 cases the workers (4.6%) perceived that they had received detriment for having spoken up.

This compares with an average of 43 cases per trust per year and an average of 5% workers perceiving detriment.

The trust needs to listen to the perceptions of its workers and to ensure that their policy offers the protection that it describes.

We refer to recommendation 7 (p. 19) to address our findings in this regard.

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## 7. Settlement agreements

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### Background information

A settlement agreement is a legally binding document that sets out the agreed terms and conditions between an employer and a worker to resolve a dispute between them, or to terminate the worker's contract of employment.

Settlement agreements can have common features, including an agreed financial payment to be made to the worker, as well as an agreement from the worker to waive their right to bring claims under their contract of employment, for example at an employment tribunal.

They can also contain confidentiality clauses, where the parties agree not to reveal specific aspects of the agreement, including the existence of the agreement itself.

The use of confidentiality clauses in settlement agreements in the public sector, particularly where they prevent the parties from disclosing the existence of the agreement itself, has been the subject of criticism. This has included House of Commons Public Accounts Committee, which expressed the concern in 2013 that such clauses were used inappropriately "may deter former employees from speaking out about serious and systematic failures within the public sector, for example, in patient care or child safety."<sup>11</sup>

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<sup>11</sup> <https://publications.parliament.uk/pa/cm201314/cmselect/cmpubacc/477/477.pdf>

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Legally, any provision in a settlement agreement that seeks to prevent an employee from making a protected disclosure<sup>12</sup> under the Public Interest Disclosure Act is void.<sup>13</sup>

A protected disclosure is determined to have occurred when an employment tribunal rules that a worker has disclosed certain information in specific, legally defined circumstances. Circumstances where such rulings are made include where an employer and a worker disagree whether a concern raised qualifies for protection.

Tribunals may award compensation to workers who have made protected disclosures where it is shown that they suffered detriment for having done so.

The Secretary of State for Health in 2013<sup>14</sup> stated that the Government “would not approve any [settlement agreements] with a confidentiality clause that prevents people speaking out about patient safety or patient care”. In the same year the minister also wrote to all NHS trust chairs to ask them to check that their trusts’ use of settlement agreements supported ‘an open NHS culture’.<sup>15</sup>

Guidance for NHS organisations on the use of settlement agreements was published by NHS Employers in 2013.<sup>16</sup> This guidance reminds NHS organisations that settlement agreements must legally contain a provision relating to a worker’s right to make a protected disclosure, as well as patient safety issues in accordance with their professional and ethical obligations and provides a recommended form of words for such clauses.

It is also a provision of NHS organisations’ standard contract with NHS England that they will not ‘prevent or inhibit’ their workers, or sub-contractors, from making a protected disclosure.<sup>17</sup>

## Why we looked at settlement agreements in this case review

We looked at the issue of settlement agreements because a former worker, who had previously signed a settlement agreement with the trust, told us that they believed that the trust had unlawfully used that agreement to prevent them from speaking up.

The agreement had been drawn up in accordance with the above guidance from NHS Employers and included provisions stating that although the worker could not raise any complaint or grievance relating to their employment this did not include those that amounted to protected disclosures under the Public Interest Disclosure Act or in line with professional duties.

The former worker said the trust acted unlawfully in its use of the settlement agreement because it refused to investigate issues the individual raised about their employment. The former worker said

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<sup>12</sup> <https://www.legislation.gov.uk/ukpga/1996/18/part/IVA>

<sup>13</sup> <https://www.legislation.gov.uk/ukpga/1996/18/section/43J>

<sup>14</sup> <https://www.dailymail.co.uk/news/article-2293000/Victory-NHS-whistleblowers-After-Daily-Mail-campaign-Health-Secretary-bans-gagging-orders-NHS-staff.html>

<sup>15</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/217036/open-culture-letter.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/217036/open-culture-letter.pdf)

<sup>16</sup> <http://www.nhsemployers.org/~media/Employers/Publications/settlement-agreements.pdf>

<sup>17</sup> <https://www.england.nhs.uk/wp-content/uploads/2018/01/3-nhs-standard-contract-1718-1819-general-conditions-full-length-v2.pdf>

that they had raised these issues multiple times in accordance with the trust's speaking up policies and procedures. The trust reused to investigate the issues on the grounds the settlement agreement prevented the worker from speaking up about such matters. By contrast, the former worker asserted they were, in fact, making protected disclosures, and therefore the trust had a duty to investigate them.

It is not within the remit of the National Guardian's Office to pass any comment on whether any organisation has acted lawfully or not. However, as we describe below, the form and content of settlement agreements are highly relevant to speaking up cultures in the NHS. For this reason, the NGO is currently working with its partners, including the Department of Health and Social Care and NHS Employers to improve clarity about the nature, scope and use of settlement agreements in the NHS, with the intention of preventing misuse and barriers to speaking up.

Therefore, we describe below the potential issues relating to settlement agreements that we have observed and on which we are working with our partners to resolve.

## Potential issues with settlement agreements

### **Making agreements easier to understand for workers**

We saw the settlement agreement used in relation to the trust worker described above. The document was not easy to understand. Many of the clauses were long and complex and contained legalistic language.

With our partners we will look at the use of plain English, to help assist workers to understand their rights and obligations.

### **Supporting learning and patient care and safety**

It is common for settlement agreements to contain clauses stating that the worker agrees not to raise any complaints or grievances with the employer about their former role. Such a provision was included in the agreement we saw during our review.

The rationale for the inclusion of such clauses is understood, as the purpose of many settlements is not only to agree the terms on which a worker's employment will end, but also to agree an end to any disputes relating to that employment.

However, a settlement agreement that prevents the worker raising matters about their former employment arguably prevents, at the same time, the employer from investigating such issues and therefore from also discovering any potentially important learning from those issues.

As set out above, settlement agreements may not preclude workers from raising issues that are protected under the Public Interest Disclosure Act. The guidance from NHS Employers referred to above also says that settlement agreements should not prevent workers from speaking up about patient safety, in accordance with their professional and ethical obligations.

The National Guardian's Office and its partners will consider whether these provisions go far enough in supporting workers to speak up about patient safety matters, or whether they need to be stated more clearly.

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## Confidentiality clauses

As described above, confidentiality clauses are often used in settlement agreements and are terms where the parties agree not to reveal specified aspects of the agreement, including sometimes the existence of the agreement itself.

Such clauses may have an unintended detrimental impact upon the worker. For example, a worker seeking support to deal with the stresses relating to the ending of their employment, for example from a clinician or counsellor, may be prevented by a confidentiality clause from discussing the details of the very issues that are the source of their distress.

Another unintended negative impact of clauses that prevent workers from disclosing their existence may be in relation to the whistleblower employment support scheme<sup>18</sup>. The scheme was launched by NHS Improvement in 2017 to help NHS workers in secondary care who have suffered detriment because of speaking up to find alternative employment within the NHS.

The scheme offers support to those who are having difficulties finding employment in the NHS where they previously experienced detriment for speaking up in a former NHS role. However, where a worker has signed an agreement containing a confidentiality clause preventing them disclosing the agreement's existence, it is possible they may be deterred from accessing the scheme, in the belief that they will have to reveal their settlement agreement in order to apply for it.<sup>19</sup>

A similar scheme for whistleblowers in primary care was also launched by NHS England in 2017. The National Guardian's Office and its partners will therefore consider the impact of confidentiality clauses on the wellbeing of workers, as well their possible impact on the openness of NHS culture.

## Inspection of settlement agreements

To help ensure that future settlement agreements support the needs of individual workers and the NHS as a whole, the NGO and its partners will consider the role regulators can play in reviewing their use, including whether they are in accordance with national guidance.

## Updating national guidance

The NGO will work with its partners to ensure that national guidance for the use of settlement agreements better supports a positive speaking up culture in the NHS and reflects agreed best practice.

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<sup>18</sup> <https://improvement.nhs.uk/events/whistleblowers-support-scheme-launch/>

<sup>19</sup> NHS Improvement wrote in 2018 to trusts asking them not to enforce confidentiality clauses against workers seeking to access the Whistleblower Support Scheme. At the time of writing of this report NHS Improvement had not received any expressions of concern from trusts relating to this request.



## Our recommendation

The National Guardian's Office therefore makes a recommendation for itself and its partners in relation to the review of the use of settlement agreements in the NHS.

### Recommendation 8

**Within 3 months the National Guardian's Office and its partners involved in reviewing settlement agreements in the NHS, including the Department of Health and Social Care, NHS Employers and NHS Improvement, should complete this review and take all appropriate steps to implement its findings.**

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## B. Findings regarding the trust's speaking up arrangements

### 1. The trust's speaking up policy

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At the time of our review the trust was in the process of updating its speaking up policy ('Freedom To Speak Up: Raising Concerns Policy') to ensure that it was in accordance with the national, integrated speaking up policy for the NHS, published by NHS Improvement.

We asked NHS Improvement to provide feedback on the trust's updated policy for the purposes of this review report, which was as follows:

#### Overall

The policy is good. It incorporates a significant proportion of the national policy, has trust specific details and contact details for relevant individuals, and really helpful flowchart at the start, which is brilliant.'

#### Main areas for improvement

The policy describes supporting workers to speak up who have "*a reasonable belief*" that something has, or may have gone wrong. NHS Improvement comment that this language is not helpful as it is taken from the Public Interest Disclosure Act, which only provides support to workers in limited circumstances.

The trust's policy also makes further references to the Act in relation to "*protected disclosures*". NHS Improvement comments that the reference 'does not appear to reflect current legal requirements', nor the national speaking up policy for the NHS, which 'seeks to move beyond quoting the legislation'.

The scope of the policy is unnecessarily repeated

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The feedback regarding necessary improvements reflects comments the National Guardian's Office has previously made repeatedly in its published case reviews<sup>20</sup>, particularly in relation to unnecessary references in speaking up policies to the Public Interest Disclosure Act.

We remind all trusts that we expect them to implement our recommendations, where appropriate and that assessment of this aspect of governance forms part of the Care Quality Commission inspectors' evaluation of how well led trusts are.

We therefore recommend that the trust amends its policy to take account of the feedback from NHS Improvement and takes steps to communicate the revised policy to all its workers.

At the time of writing this review we understand that NHS Improvement are planning to update its national speaking up policy. We therefore also suggest that the trust updates its policy relating to the feedback above once these changes are known.

## Recommendation 9

**Within 3 months the trust should revise its new speaking up policy, to ensure it is in line with the NHS Improvement national speaking up policy.**

## Recommendation 10

**Within 6 months the trust should take steps to ensure all existing and new workers are aware of the contents and meaning of its revised freedom to speak up policy.**

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## 2. Measuring the effectiveness of speaking up

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We asked senior trust leaders how they intended to measure the effectiveness of speaking up policies and processes to ensure that they were meeting the needs of trust workers and promoting a positive speaking up culture.

The importance of monitoring the effectiveness of speaking up arrangements was highlighted in our case review report for Southport and Ormskirk NHS trust, published in November 2017.<sup>21</sup>

At the time of our review, trust leaders agreed that it was important to monitor the effectiveness of the organisation's speaking up arrangements, with several observing that the trust annual NHS staff survey provided important information in this regard. One trust leader also said that the organisation was planning to develop their trust's use of the exit interview for staff ending their employment so that feedback could be obtained about their view of the speaking up culture.

While we commend the use of the exit interview process for this purpose, it was clear that the trust did not have a dedicated or strategic approach as to how to measure the effectiveness of its speaking up arrangements, either in terms of what information it would, or how it would use it.

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<sup>20</sup> <https://www.cqc.org.uk/national-guardians-office/content/case-reviews>

<sup>21</sup> [https://www.cqc.org.uk/sites/default/files/20171115\\_ngo\\_southportormskirk.pdf](https://www.cqc.org.uk/sites/default/files/20171115_ngo_southportormskirk.pdf)

As well as appointing Freedom to Speak Up Guardians and implementing appropriate policies trust leaders must take steps to assure themselves that the culture and processes of their organisation meets workers' needs. This important role for trust leaders is highlighted in the speaking up guidance for trust boards, published in May 2018:

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*“All senior leaders take an interest in the trust’s speaking up culture and are proactive in developing ideas and initiatives to support speaking up. They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.”*

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We therefore recommend that the trust takes appropriate steps to address this.

## Recommendation 11

**Within 6 months the trust should put effective systems in place to monitor the development of a positive speaking up culture.**

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### 3. Speaking up training

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At the time of our review the trust told us that they had recently commissioned training for its newly appointed freedom to speak up champions. This training was given by an external provider.

We recognise that freedom to speak up has made significant progress over the previous two years and during that time the NGO and NHS Improvement have issued guidance and training materials. In light of this, training organisations may have found it difficult to keep pace with these developments.

We make these observations based on the training slides we saw during our review:

- The National Guardian's Office advocates a consistent use of the term 'speaking up' to describe any matter that gets in the way of delivering great care. This embraces not only early alerts to potential problems, but also encourages suggestions for change and improvement. The use of the word 'whistleblowing', as seen in the slides, is often used to define more narrow issues such as very serious matters including the Public Interest Disclosure Act<sup>22</sup>, or both.
- The training distinguished between 'grievances' and 'concerns' which risks implying that these may not all be speaking up matters. The NGO believes that all issues a worker may want to raise should fall under the description of 'speaking up'. This allows workers raising any issue to receive support and for a holistic approach to speaking up matters to be taken so that potential patient safety issues are not missed.
- The training materials suggest that freedom to speak up champions should consider which issues to record. The National Guardian's Office guidance to guardians is that all cases raised

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<sup>22</sup> q.v. Public Interest Disclosure Act - <https://www.legislation.gov.uk/ukpga/1998/23/contents>

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through their own network should be recorded. The NGO first issued guidance on recording in February 2017.<sup>23</sup>

- The training contained several references to the Public Interest Disclosure Act. As the NGO has observed in all its previous case review reports, it is unhelpful to focus on this legislation, whether in speaking up policies or training, as it may act as a barrier to workers thinking about speaking up.
- The training did not appear to reference previously published developments in speaking up, including recommendations and guidance from the National Guardian's Office and NHS Improvement's national speaking up policy.

Our observations lead us to conclude that, in this fast-moving landscape, it would be helpful for the National Guardian's Office to create national guidelines to assist training providers and trusts to meet our expectations.

Therefore, in addition to making a recommendation for trusts about the speaking up training they provide, we also make a recommendation for our own office to provide national guidelines regarding the content of such training.

## **Recommendation 12**

**Within 6 months the National Guardian's Office should draw up national guidelines for the NHS relating to the content of speaking up training for workers.**

## **Recommendation 13**

**Within 12 months the trust should ensure that the content of any speaking up training it provides for its workers is consistent with guidance issued by the National Guardian's Office and NHS Improvement, including findings and recommendations from NGO case reviews and the Freedom to Speak Up Survey 2018 and board guidance from NHSI**

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## **4. Freedom to Speak Up Guardian**

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In accordance with obligations under the NHS England standard contract the trust had appointed a Freedom to Speak Up Guardian. The purpose and expectations of the role, as set out by the NGO<sup>24</sup> are as follows:

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<sup>23</sup> [https://www.cqc.org.uk/sites/default/files/20180719%20Guidance%20on%20Recording\\_0.pdf](https://www.cqc.org.uk/sites/default/files/20180719%20Guidance%20on%20Recording_0.pdf)

<sup>24</sup> [https://www.cqc.org.uk/sites/default/files/20180213\\_ngo\\_freedom\\_to\\_speak\\_up\\_guardian\\_jd\\_march2018\\_v5.pdf](https://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf)

## Purpose

Freedom to Speak Up Guardians help:

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- Protect patient safety and the quality of care
  - Improve the experience of workers
  - Promote learning and improvement
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By ensuring that:

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- Workers are supported in speaking up
  - Barriers to speaking up are addressed
  - A positive culture of speaking up is fostered
  - Issues raised are used as opportunities for learning and improvement
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## Expectations

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- Guardians operate independently, impartially and objectively, whilst working in partnership with individuals and groups throughout their organisation, including their senior leadership team
  - Seek guidance and support from and, where appropriate escalate matters to bodies outside their organisation
  - Support, and contribute to, the national Freedom to Speak Up Guardian network, comply with National Guardian Office guidance, and support each other by providing peer-to-peer support and sharing learning
  - Should be supported with the resources they need, including ring-fenced time, to ensure that they meet the needs of workers in their organisation. Their views on the impact of activities and decisions on Freedom to Speak Up should be actively sought
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The Guardian in the trust was appointed in June 2017, using an open and fair process. This was in accordance with guidance issued by the National Guardian's Office on the implementation of the role.<sup>25</sup>

The Guardian was employed two days a week and was supported by a network of 10 champions, who undertook the role on a voluntary basis, to help workers to speak up across the widely dispersed geography of the trust.

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<sup>25</sup> [https://www.cqc.org.uk/sites/default/files/20170915\\_Freedom\\_to\\_Speak\\_Up\\_Guardian\\_Survey\\_2017.pdf](https://www.cqc.org.uk/sites/default/files/20170915_Freedom_to_Speak_Up_Guardian_Survey_2017.pdf)

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The Guardian reported regularly to the trust board on updates to the trust's speaking up arrangements. Guidance for trust boards on speaking up from NHS Improvement<sup>26</sup> identifies what such reports can contain:

## Assessment of issues

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- information on what the trust has learnt and what improvements have been made as a result of trust workers speaking up
- information on the number and types of cases being dealt with by the FTSU Guardian and their local network
- an analysis of trends, including whether the number of cases is increasing or decreasing; any themes in the issues being raised (such as types of concern, particular groups of workers who speak up, areas in the organisation where issue are being raised more or less frequently than might be expected); and information on the characteristics of people speaking up (professional background, protected characteristics)

## Potential patient safety or workers experience issues

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- information on how FTSU matters relate to patient safety and the experience of workers, triangulating data as appropriate, so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve can be built

## Action taken to improve FTSU culture

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- details of actions taken to increase the visibility of the FTSU Guardian and promote the speaking up processes
- details of actions taken to increase the visibility of the FTSU Guardian and promote the speaking up processes
- details of action taken to identify and support any workers who are unaware of the speaking up process or who find it difficult to speak up
- details of any assessment of the effectiveness of the speaking up process and the handling of individual cases
- information on any instances where people who have spoken up may have suffered detriment and recommendations for improvement
- information on actions taken to improve the skills, knowledge and capability of workers to speak up and to support others to speak up and respond to the issues they raise effectively

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<sup>26</sup> [https://improvement.nhs.uk/documents/2468/Freedom to speak up guidance May2018.pdf](https://improvement.nhs.uk/documents/2468/Freedom%20to%20speak%20up%20guidance%20May2018.pdf)

## Learning and improvement

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- feedback received by FTSU Guardians from people speaking up and action that will be taken in response
- suggestions of any priority action needed
- updates on any broader developments in FTSU, learning from case reviews, guidance and best practice

## Recommendations

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We saw three of these reports, which showed that the level of detail improved over time. The most recent of which showed a commendable level of detail, including many of the areas described in the above guidance.

Earlier reports were less detailed. We therefore recommend that the level of content of the most recent trust report continues.

The role of the Guardian was advertised across the trust via a variety of methods, including posters and through the trust internal communications system. Most workers we spoke to were aware of the role and many knew the identity of the staff member who undertook the role.

We asked trust leaders about the amount of ring-fenced time they had allocated for the Guardian role, given the number of concerns expressed by many workers to our review regarding the poor speaking up culture in the trust. In response, a senior leader told us that the trust planned to provide resources for the role to be undertaken full-time, to meet the needs of workers, although they did not state when this would specifically happen.

Given the clear need to improve the speaking up culture across the trust we endorse the trust's commitment to providing appropriate resources for the Guardian role and recommend that the trust implements this plan without undue delay.

### Recommendation 14

**Within 3 months the trust should take appropriate steps to identify the necessary resources required to ensure the Guardian role meets the needs of workers and then provide those resources.**

### Recommendation 15

**Within 3 months the trust should ensure that reports for board members regarding the trust's speaking up arrangements continue to contain appropriate levels of detail, in accordance with the joint guidance from NHS Improvement and the National Guardian's Office.**

What will happen next

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## **An action plan from the trust to implement our recommendations**

Following publication of this report, NHS Improvement, which is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care, will ask the trust to produce an action plan to implement our recommendations, within the timescales we have set.

It is the NGO's expectation that NHS Improvement will ask trusts to publish their action plans.

Once the trust puts their plan into effect NHS Improvement will monitor the trust's implementation of that action plan and will provide the NGO with updates regarding its progress.

Where there is evidence that the trust has not taken effective actions to implement our recommendations we will expect NHS Improvement, as well as Care Quality Commission inspectors, to take appropriate steps to address this.

The National Guardian's Office will also publish an update on the work it is undertaking with its partners to develop guidance relating to settlement agreements. In addition, it will produce national guidance within the required timescales on speaking up training.

## **Our response to individual contributors to our review**

The National Guardian's Office will contact those individuals who have spoken up to our review, thanking them and providing feedback to them on how their experiences have been reflected in this report. We will also ask them for feedback on their experience of how we have conducted this review.

In addition, we will contact staff who spoke to us individually during the review to confirm whether they have subsequently experienced any detriment for speaking up. Where they tell us this has taken place we will refer any such cases to the trust and, if necessary, regulators to take appropriate action.

## **Other NHS trusts' responsibilities to implement our recommendations**

We expect all other NHS trust boards in England, in accordance with the guidance we have produced in collaboration with NHS Improvement, to implement this report's recommendations in their own services, where it is appropriate to do so.

## **Feedback to help improve our case review process**

To help us improve our process we welcome feedback from all readers of this report. Please send your comments to: [casereviews@nationalguardianoffice.org.uk](mailto:casereviews@nationalguardianoffice.org.uk)



# Annex – summary of recommendations

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The recommendations arising from the case review are listed below.

They are grouped according to when we recommend the work is completed by the body in question to implement each recommendation.

We also list below those recommendations for improvement that we have not made in previous reviews, to assist trusts to undertake gap analysis of this report relating to their own speaking up arrangements and culture.

## Recommendations to be completed within three months

### **Recommendation 5**

Within 3 months the trust should take appropriate steps to ensure that its response to workers speaking up, including the investigations of those issues and the implementation of learning resulting from them, is undertaken by suitably independent trained investigators.

### **Recommendation 6**

Within 3 months the trust should take appropriate steps to ensure that the confidentiality of workers who speak up is appropriately supported, in accordance with trust policy and procedure and good practice.

### **Recommendation 7**

Within 3 months the trust should ensure that it responds to the issues raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice.

### **Recommendation 8**

Within 3 months the National Guardian's Office and its partners involved in reviewing settlement agreements in the NHS, including the Department of Health and Social care, NHS Employers and NHS Improvement, should complete this review and take all appropriate steps to implement its findings.

### **Recommendation 9**

Within 3 months the trust should revise its new speaking up policy, to ensure it is in line with the NHS Improvement national speaking up policy.

### **Recommendation 14**

Within 3 months the trust should take appropriate steps to identify the necessary resources required to ensure the Guardian role meets the needs of workers and then provide those resources.

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### **Recommendation 15**

Within 3 months the trust should ensure that reports for board members regarding the trust's speaking up arrangements continue to contain appropriate levels of detail, in accordance with joint guidance from NHS Improvement and the National Guardian's Office.

## **Recommendations to be completed within six months**

### **Recommendation 4**

Within 6 months the trust should review incident reporting rates and identify any areas which appear to be under-reporting and take action to address this.

### **Recommendation 10**

Within 6 months the trust should take steps to ensure all existing and new workers are aware of the contents and meaning of its revised freedom to speak up policy.

### **Recommendation 11**

Within 6 months the trust should put effective systems in place to monitor the development of a positive speaking up culture.

### **Recommendation 12**

Within 6 months the National Guardian's Office should draw up national guidelines for the NHS relating to the content of speaking up training for workers.

## **Recommendations to be completed within twelve months**

### **Recommendation 1**

Within 12 months the trust takes appropriate measures to identify the causes of poor working relationships across the whole organisation and implements effective actions to remedy those causes, including steps to measure the effectiveness of those actions.

### **Recommendation 2**

Within 12 months the trust takes steps to implement national guidance from NHS England relating to the managing of conflicts of interest.

### **Recommendation 3**

Within 12 months trust leaders develop and begin the implementation of a strategy to improve the speaking up culture across its workforce. The plan should contain measures to identify the main issues the trust should address, clear actions to address those issues and steps to measure the effectiveness of those actions.

### **Recommendation 13**

Within 12 months the trust should ensure that the content of any speaking up training it provides for its workers is consistent with guidance issued by the National Guardian's Office and NHS Improvement, including findings and recommendations from NGO case reviews and the Freedom to Speak Up Survey 2017 and board guidance from NHSI.

## Recommendations in this report that we are making for the first time in a case review report

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- Recommendation 1
  - Recommendation 8
  - Recommendation 12
  - Recommendation 13
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