# Report to the Board of Directors 2014/15

<table>
<thead>
<tr>
<th>Date of meeting</th>
<th>27 March 2015</th>
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<tbody>
<tr>
<td><strong>Subject</strong></td>
<td>Overview of the Freedom to Speak Up Review undertaken by Robert Francis</td>
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<tr>
<td><strong>Report of</strong></td>
<td>Interim Director of Workforce &amp; Corporate Affairs</td>
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<tr>
<td><strong>Prepared by</strong></td>
<td>Geraldine Opreshko, Interim Director of Workforce &amp; Corporate Affairs</td>
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<tr>
<td><strong>Previously considered by</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Question(s) addressed in this report</strong></td>
<td>The Board is asked to note the content of this significant report and discuss the recommendations in relation to access to senior leaders by staff.</td>
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<tr>
<td><strong>Board Action Required</strong></td>
<td>Approval</td>
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<td></td>
<td>Decision</td>
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## Executive Summary, purpose and recommendation(s)

This long awaited review was set up in response to the continuing disquiet about the way NHS organisations deal with concerns raised (whistle blowing) by NHS staff and particularly the treatment that many have experienced having raised those concerns.

The paper provides a concise overview of the report published on 11 February 2015 and highlights the work already in train at James Paget University Hospital.

The Board is asked to confirm that the work undertaken is sufficient to meet requirements.
<table>
<thead>
<tr>
<th>Strategic Context/Objective(s) and Board Assurance Framework links</th>
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| **Strategic aim(s)** | 2 – Ensure our Patients receive the best possible experience  
5 - Develop our staff, ensuring they are supported to meet their strategic objectives and to provide innovative and sustainable services for our patients |
| **Strategic objective(s)** | 1 - Implement the first year's objectives of the Trust's Quality Strategy  
12 - Further embed the Values and Behaviours Framework as part of the Organisational Development Strategy to achieve a Culture of Excellence |
| **BAF reference(s)** | 1c, 12a |

This paper provides assurance against the Trust objective(s) identified X

This paper is to close a gap in control/assurance in relation to the objective(s)

<table>
<thead>
<tr>
<th>Legal/regulatory (relevant legislation and specific reference where appropriate)</th>
<th>Care Quality Commission Fundamental standards – Fit and Proper Person and Well Lead Domain</th>
</tr>
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<tbody>
<tr>
<td><strong>Equality Impact/risks:</strong> (Equality Delivery System 2 – EDS2 Nov 2013)</td>
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Impact  
P | Positive | Negative | Neutral |
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<tr>
<td><strong>Assurance/monitoring</strong></td>
<td>To be agreed at Private Board</td>
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**REVISED DEFINITIONS**

**Information:** Update to ensure Board has sufficient knowledge on subject matter and to provide assurance on progress

**Discussion:** seeking Board members’ views, potentially ahead of final course of action being agreed

**Decision:** when being asked to choose between alternative courses of action

**Approval:** positive resolution, to confirm paper is sufficient to assure the Board in its ongoing monitoring role, or to address a gap in control

270315 Freedom to Speak up  
Geraldine Opreshko, Interim Director of Workforce & Corporate Affairs  
18 March 2015  
REP/BOD/GO1803/01
Freedom to Speak up – An independent review into creating an open and honest reporting culture in the NHS

Introduction

The review Sir Robert Francis has undertaken over the last seven months into whistleblowing and creating an open culture across the NHS was published on 11 February 2015.

It recommends wide ranging reform of culture in healthcare to ensure that staff feel safe to raise concerns over patient safety and treatment without fear of reprisal.

‘Freedom to speak up’ has been an in depth review, producing a comprehensive report which is a detailed description of what staff, employers, unions and national bodies have told the review team. It also includes the outcomes of research and international comparisons that have been undertaken. The report details some good practice that is taking place and also reveals how some staff in the NHS have not been treated as we would want and expect.

To address the gap and variation, the report covers how organisations can create the right culture, how concerns should be handled and what is needed to make the system work.

The content

It has two over-arching recommendations, 20 principles and 36 specific actions that cover local and national organisations and they have been grouped under five key themes. These are:

- the need for culture change
- improved handling of cases when concerns are raised
- measures to support good practice
- particular measures for vulnerable groups
- additional legal protection.

The focus of the whole package is ensuring issues are dealt with as patient safety issues. The Secretary of State has already confirmed that he is “accepting all recommendations in principle” and that NHS-specific legislation will be introduced before the election.

With many of the local actions, there are parallel recommendations to system regulators about how they assess this against whether an organisation is well-led. It does also note that Care Quality Commission (CQC) concepts of the well-led organisation and the recent introduction of the fit and proper persons requirement need to be given time to take effect.

The review is clear that the culture change, which is such a priority of the recommendations, needs to be achieved by effective, visible leadership, instilling teamwork and reflective practices and not promoting a culture of hierarchy

The two over-arching recommendations are:

1. All organisations should implement the principles and actions in the report in line with the good practice outlined.

2. The Health Secretary reviews progress at least once a year against the actions in the report.
Overview of the Key principles (themed)

Culture (Principles 1 to 6)

A full six of the 20 principles deal specifically with culture. These cover safety, raising concerns, culture free from bullying, visible leadership, valuing staff and reflective practice.

Improved handling of cases (Principles 7-9)

This covers the organisational structure to facilitate both informal and formal raising of concerns, prompt, swift and blame free investigations where concerns are raised and where possible the use of expert interventions to resolve conflict and re-build trust.

Measures to support good practice (Principles 10 -17)

As well as recommending training for every member of staff (curriculum development by HEE and NHS England) it also covers the “Freedom to Speak Up Guardians” (principle 11). Although this will not be a legal requirement, the Review recommends that trusts consider appointing a “Freedom to Speak Up Guardian”, to whom staff know they can go to raise concerns. The guardian should be independent and impartial, have the authority to speak to anyone within or outside the trust, be expert in all aspects of raising and handling concerns, have the tenacity to ensure safety issues are addressed, and have the dedicated time to perform this role. This is the “ambassador for cultural change” principle which has been successfully developed by Helene Donnelly (previously an A&E staff nurse at Stafford Hospital) now at Stoke on Trent Partnership NHS Trust, and who supported Sir Robert in the launch of the Review.

Principle 12 details support to find alternative employment in the NHS where current and former NHS whistle-blowers “whose performance is sound” often encounter problems when seeking alternative employment within the NHS. All NHS organisations should actively support a scheme which is likely to be developed by the Trust Development Authority (TDA) and Monitor.

Further areas covered by this theme include the use of settlement agreements; accountability of everyone for adopting fair, open and honest behaviours when raising, receiving or handling concerns; a proposal for an independent national officer (INO); more co-ordinated regulatory action; and the CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of vulnerable workers who raise concerns. (Well led- domain)

Measures for Vulnerable Groups (Principles 18 and 19)

The Review defines these groups as locums, agency and bank staff, students and trainees, and staff from black and minority ethnic backgrounds. Of related concern is the position of staff in primary care.

Legal Protection (Principle 20)

Some key steps are proposed:
• Extending prescribed persons (bodies to whom protected disclosures can be raised in law) to include NHS England, all Clinical Commissioning Groups (CCGs) and all Local Education and Training Boards (LETBs).
• Extending discrimination legislation to protect people who are seeking employment, from discrimination on the grounds that they are known to be a whistle-blower. The Secretary of State for Health has already confirmed that this will be introduced in this Parliament.

Finally, reform is already underway to extend protection to all healthcare students.

Government response

After the release of the report the Health Secretary sent a letter to every NHS trust chair and TDA/Monitor wrote to every chief executive to reinforce the importance of staff being able to discuss concerns openly in teams and for action to be taken.

The Chief Executive of JPUH wrote out to every member of staff in the same vein.

Further the Health Secretary specifically stated that each organisation should act now to appoint a local guardian who staff can approach to raise concerns and who has a direct reporting line to the chief executive.

External review – an Independent National Officer (Principle 15)

As mentioned above the Review also recommends the appointment of an Independent National Officer (INO), jointly established and resourced by the CQC, Monitor, the NHS TDA and NHS England. The INO would be authorised to review the handling of concerns raised by NHS workers and/or their treatment, advise organisations on appropriate action, act as a support for Freedom to Speak Up Guardians, and provide national leadership and good practice guidance. The INO will not, however, have its own binding powers, and will be reliant on the regulatory bodies to implement its recommendations.

James Paget University Hospitals’ response and actions so far:

As the Freedom to Speak Up Review makes clear this report is about a fundamental reform in NHS culture. Since the Francis Hard Truths report JPUH has:

• Developed a Quality Strategy in September 2013 monitored by the Board, this includes:
  – Education and training around Never Events
  – Medicines management
  – Improved patient documentation
  – Prioritised clinical audits
  – Complete review of how patient experience information is used
  – Improved communication with patients, relatives, carers
  – Improved response to complaints and transparency to Board
• Extensive work to develop and embed our values and behaviours
• Health and wellbeing initiatives planning underway
• Management and clinical leadership development programmes
• Board line of sight on patient safety
• Board to ward visits re-established
• ‘Remarkable’ branding throughout currently being refreshed, OD strategy
• Nursing staffing levels reported monthly to Board
• Review of Raising Concerns policy
• Via Occupational Health a confidential employee assistance programme
• A pocket sized card circulated to all staff with the February 2015 payslip on raising concerns and how to ‘speak up’
• Staff have access to advice and support from an external organisation (eg, whistleblowing helpline) promoted on the pocket card and in the policy.
• A programme of executive lead sessions across all staff groups to support Freedom to Speak Up
• A confidential email address for all staff – raisingconcerns@jpaget.nhs.uk – accessible only by the Chief Executive Officer and Director of Workforce
• From January 2015 reporting of any concerns raised visible at the private Board

A publicity campaign will also follow specifically on raising concerns to include posters, screensavers and use of social media.

Members of the executive team are currently attending as many existing forums as possible for example team meetings, Grand Round, student forums, clinical leaders, to talk about the importance of raising concerns and also to ask what would help them feel safe in doing so.

Freedom to Speak Up also recommends a person is appointed locally by the chief executive to act as a 'Freedom to speak up guardian'. This is a proposal that we are specifically discussing when we meet with staff and teams face to face to ascertain their views on what would work most effectively for them.

Geraldine Opreshko
Interim Director of Workforce & Corporate Affairs
March 2015