realisation collaborative

Freedom to **speak up**

An independent review into creating an open and honest reporting culture in the NHS

Summary report on the key points from four seminars with review contributors

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INTRODUCTION

The Freedom to Speak Up Review, Chaired by Sir Robert Francis, was set up in June 2014 by the Secretary of State for Health. In October and November 2014 the review team organised four seminars designed to help Sir Robert Francis QC hear from different interest groups about the changes they thought would be most effective in creating an open and honest reporting culture.

The first three seminars concentrated on the different stages involved when people speak up: raising concerns (London, 17 October), handling concerns (Newcastle, 22 October) and resolution and moving on (Birmingham, 23 October) (although participants were able to comment on all three stages). A fourth and final seminar (London, 11 November) provided the opportunity to test emerging solutions identified throughout the review process.

This report summaries the key points arising from these events.

RAISING CONCERNS

A safe and open culture

A safe and open culture in which people are encouraged to speak up about concerns as a normal part of their working life was emphasised throughout the seminars. We asked participants to identify what organisations/employers can do to establish a culture in which people feel confident in raising concerns. Their suggestions included:

- Promoting a strong framework of values and behaviours
- having clear policies for promoting patient safety and raising concerns and demonstrating that these arrangements are being used and are effective
- a blame free approach to patient safety and holding people to account for the way they behave toward each other
- a range of methods through which staff can make suggestions, discuss concerns and their feelings about the delivery of care (e.g. Schwarz rounds, chatrooms on the intranet and suggestion boxes);
- encouraging clinical teams to develop a shared picture of what 'good care' looks like and have regular discussions about care that falls below this standard
- establishing internal mentoring arrangements for less senior/experienced staff – mentors can help people to talk through their concerns and support them in making their views known through the appropriate procedures
- providing training on raising and investigating concerns including how to have difficult conversations with colleagues about safety, quality or behaviour issues
- making more widespread use of 360 degree feedback and appraisals
- providing transparent feedback about of how concerns have been handled and the lessons learned
- investing in mediation skills to provide support to individuals and teams experiencing difficult relationships
- checking that people do not suffer any detriment as a result of speaking up

- recognising and valuing people who raise concerns
- taking the Duty of Candour seriously and admitting faults where they arise
- ensuring that senior leaders are role models, demonstrating through their behaviour that they value concerns being raised and take them seriously
- having a set of indicators and measures that the Board can use to assess whether a safe and open culture is evident in their organisation.

Participants were asked about whether the NHS should take a 'zero tolerance' approach to bullying and if so, how this might work. While there was agreement that bullying is a serious issue that must be tackled head on, there were more equivocal views about whether 'zero tolerance' is realistic, given that bullying is open to interpretation. Some went as far as to say that terms such as 'bullying' and 'harassment' are misleading and that it would be more effective to focus on respectful behaviours. The majority of comments concerned positive actions that could help with early identification of bullying/disrespectful behaviour and support for those affected. One suggestion, for example, was building training on respectful relationships into pre-registration training.

Raising concerns in smaller organisations such as GP practices was felt to be potentially more difficult than in larger organisations. Not all practices, for example, have a policy for raising concerns, even though there are sample policies that they can adapt for use locally (available from the http://www.wbhelpline.org.uk/resources/raising-concerns-at-work). GPs potentially have more options for raising concerns and securing support than practice staff such as managers, nurses and receptionists. Doctors can seek advice or support from the Local Medical Committee (LMC), from clinical leaders on the Clinical Commissioning Group (CCG) where appropriate, their responsible officer (the person who oversees their license to practice on behalf of the General Medical Council (GMC)) the Medical Defence Union or, in the case of GP trainees, the Deanery. The GMC and the National Clinical Assessment Service (NCAS) were also identified as options. It was unclear whether these sources offer consistent advice and what support people can expect if they contact them.

NHS England (NHSE), the body that commissions primary services is not a prescribed body under the Public Interest Disclosure Act (PIDA). It was suggested that NHSE may not have the capacity to investigate concerns in each practice and would expect to work closely with CCGs to do so. It was felt that NHS England could do more to support the development of robust arrangements for protecting patient safety in primary care.

Terminology

Participants thought that there was confusion about the term 'whistleblowing'–people who raise concerns do not always think of themselves as whistle-blowers and the term has many negative connotations (e.g. someone who is a troublemaker or who is disloyal to their colleagues). It was clear that 'whistleblowing' means different things to different people. Most people agreed that there would be some merit in having consistency in language but there were different views about which term is best. Some felt there was little point in trying to change the term 'whistleblower' but that it was possible to shift public perception so that whistleblowing is seen in a more positive light

e.g. as a means to improve the quality and safety of care. Others argued that the more neutral term 'people who raise concerns' was a better option as it normalises the whole process of speaking up.

A clear process for raising concerns

Participants thought that in most organisations there was scope to make the process of reporting a concern easier to understand and follow. Concerns take a number of forms – from the relatively minor to very serious, from matters of patient safety, to issues concerning probity, alleged individual failings requiring performance management or ones that are about weaknesses in operational procedures. Organisations rightly have different processes in place for each type of concern so it is not always easy for people to understand which route they should take. There were mixed views about the value of national helplines, For example, some participants felt it was not always clear whether helplines were limited to giving information, whether they would actually offer advice or take over the investigation of a concern that had been lodged with them.

It is essential that health and care providers have a clear system for logging patient safety concerns which may include near misses. Many Trusts use the DATIX system to do this. While a systematic process has the advantage of enabling patterns and trends to be identified people attending the final seminar noted that this system was neither fast, nor detailed enough, to record all concerns raised at work. A further issue to be highlighted was the differences in patient safety reporting arrangements across different parts of the health system, such as primary care and hospitals. With the move toward delivering more coordinated health and care it was felt to be important that these arrangements are clearly understood by all parties or ideally, brought into alignment.

Participants were asked whether people should be allowed to raise concerns anonymously. In places where there is a safe and open culture it was suggested that there would be limited need for people to raise concerns anonymously. People want to remain 'anonymous' if they feel that the organisation is not able to give them the protection of confidentiality. Raising concerns anonymously can inhibit their investigation and the ability to provide feedback but on balance people felt it was better to have concerns raised in any form than not at all. There were different views about whether people who contact the Care Quality Commission (CQC) about concerns could expect the regulator to protect them by keeping their identity confidential – clarity about what is and is not possible would be welcomed.

Raising concerns and patient complaints

We asked people whether the processes for patient complaints and raising concerns should be aligned– both need formal recording, investigation by people not directly involved in the issue raised and methods to feed back what has happened. Participants felt that there may be some benefits but that they needed to remain separate. For example, most people were not convinced that a target completion date for concerns at work would be appropriate – for very complex concerns this could mean that they were not thoroughly investigated. It was suggested that organisations should consider triangulating patient complaints and staff concerns as this could have the potential to help them spot any patterns that need wider attention.

Recording concerns

There was strong support for a more systematic method of recording or logging concerns in the same way that organisations have a duty to record and investigate health and safety matters. The feeling was that this could help reassure people who have raised concerns and the log could help organisations spot patterns or trends and generate reports. A further suggestion was that once a concern has been logged there should be a clear statement about how the concern would be handled and what the person who raised the matter could expect from the process. It was felt that this might provide some protection against unjustified performance management processes including retaliatory referrals.

Supporting people who raise concerns – the role of ambassadors and champions

There was agreement that people who raise concerns may need some form of support but their needs will vary. We asked people about whether NHS organisations should have a Board-level lead for 'whistleblowing' and champions or ambassadors to support people who raise concerns. On balance people felt that a non-executive Board member could be useful in providing an overview and assurance of the process for raising and handling concerns. However, participants were less convinced that 'ambassadors' were the right or only way of supporting people who raise concerns. Individuals' needs, circumstances and preferences will vary. What is important is that people can easily find the type of support that's right for them both within the organisation that they work for and externally.

HANDLING CONCERNS

Options for investigating concerns

We asked participants to consider whether organisations should offer people a menu of options for handling concerns. The idea was that this might offer information about the sources of support available, a common system of defining concerns and potentially greater clarity about the different investigation routes. There were fears that it might be difficult to have a hard and fast classification covering all types of concerns or that it might be over-restrictive. Whilst some argued that NHS organisations should have freedom decide how they investigated concerns others highlighted the value of decision trees which had proved helpful in other areas such as patient safety.

Training

There was widespread support for better training to help people raise and investigate concerns – both in pre-registration training and on the job. Several groups recommended a tiered approach, which is already standard practice for some topics e.g. safeguarding. Some suggested that intermediate/advanced training could be nationally specified or accredited. Trade union representatives were identified as a specific group who needed knowledge and skills to understand the processes for raising and handling concerns and to support people through these processes.

Providing feedback

The discussions identified that lack of feedback on how concerns have been handled can deter people from raising concerns in the future. Some participants said it would be good practice to set

out the investigation process from the start, including the points at which feedback will be provided, by whom and in what format. It was noted that formal feedback should not prevent or discourage informal liaison with people who raise concerns to check how they are feeling and faring.

Handling concerns quickly and effectively

We asked participants for their views about how concerns can be handled in a speedy or timely manner. There was support for having a firm timescale for the acknowledgement of a concern being received. There was little support however, for a nationally specified timescale for completing investigations: it was acknowledged that different issues will need different solutions. There was a suggestion that individual organisations could develop criteria to identify concerns that should be 'fast tracked'.

Independent investigation

Throughout the seminars there was a good deal of debate about the value of 'independence' in the investigation of concerns. The general view was that concerns should be investigated by people who are independent of the issue being looked into and that conflicts of interest should be avoided. This did not necessarily mean concerns being investigated by people external to the organisation. In NHS Trusts for example there should be sufficient capacity to provide independent expertise internally. In small GP practices there are greater challenges in providing this assurance.

Most participants thought that there should not be an automatic right to request external independent investigation of concerns. However, participants did say there may be some circumstances where such independence would be desirable. Examples here included concerns that involve very small teams or specialties, where the issue involves technical issues that cannot be fully supported within the organisation or where there are significant disputes about what has happened. Practical suggestions were made about how the cost of sourcing independent expertise could be kept under control: they included drawing on the expertise of hospital chaplains, Healthwatch members or staff of Citizens Advice Bureaux and drawing on the skills of Foundation Trust members. A further suggestion was the development of a regional 'pool' of people trained to undertake independent investigations.

Mediation

There was support for the NHS making more use of the process, skills and language of mediation. It was noted that employers should consider developing these skills across the organisation, rather than investing the expertise in one person.

Parallel processes

Some types of concerns require investigation under parallel processes – initial patient safety concerns for example may lead to disciplinary action or grievances. We also heard about the use of 'retaliatory referrals' – situations where employers or peers may refer people who raise concerns to their professional body. The key point from the discussion was that patient safety matters should be dealt with first and foremost and that these investigations should be undertaken in blame-free way. Where matters of personal performance emerge employers needed to consider whether systemic issues may have contributed to the situation, as well as the possibilities of individual poor performance or malign intent.

Learning and sharing

Participants wanted to see the learning that arises from looking into concerns shared not only within the organisation involved but across the NHS as a whole. There was limited support, however, for formalised methods or repositories for sharing lessons/good practice as they are rarely used and can lead to additional data collection. However it was felt existing professional and organisational networks could be encouraged to take on this role.

RESOLUTION

Restoring trust and moving on

It is inevitable that in some cases there may be different viewpoints or interpretations of events that can never be fully resolved. Participants noted that if concerns are raised and investigated in a timely and effective manner, with proper feedback and support, it is more likely that those involved will find some form of resolution. Some contributors argued that there should be a 'right to reply' at the end of an investigation and/or the opportunity to request an independent review. Those who had particularly negative experiences of raising concerns wanted to see greater accountability of senior leaders, although others noted that that this might be at odds with the shift away from a blame culture. One group suggested that it would be good practice for NHS organisations to get systematic feedback from people who raise concerns: this could cover whether they felt their concern was taken seriously, their perceptions of the process and feedback, and satisfaction with the outcome.

It was noted that the people who raise concerns can (although should not) suffer detriment. The absence of any regulatory levers to prevent detriment in 'real time' leads people to rely on legal processes for restoring losses. These can be lengthy, costly and damaging. Psychological support, restorative supervision and mediation were identified as methods that could help people and teams to move on.

Return to work

We heard that the vast majority of people who raise concerns do not want to leave the organisation they are working for. It was recognised that there will be situations where retention of existing employment may not be possible. We heard a number of practical suggestions about what should be in place to support returning to work or finding alternative employment. They included

- Employers agreeing with the person who has raised concerns a validated story or statement about what has happened and what has been done. This can help to prevent rumours or misunderstandings that might be damaging either to the individual or the reputation of the organisation
- mediation or other practical support can be offered to the team e.g. to help them understand what the person who has raised concerns has been through or to work on the restoration of trust in team relationships
- safeguards, such as psychological support or simply someone to talk to, to help the person through the transition back to work

- consideration of redeployment options either within the organisation or outside if returning to the original post is either not feasible or desirable. We were told about a scheme that operates in Wales which offers redeployment opportunities for people who have raised concerns where there is not a competence or capability issue involved. The Welsh Assembly contribute to the employment costs.
- practical support e.g. with interview preparation.

It was also suggested that people who raise concerns should have the right to view the content of their electronic staff record any references provided by their employer. One group went further and argued that where people have raised concerns their employers should not comment on this in the reference that they give to the new to a new employer.

Suspension and special leave

There was general agreement that suspension and special leave had been over-used as a response to concerns raised at work. Aside from the negative financial impact on the NHS these measures can potentially lead to psychological damage for the people involved. Timely investigations, suspensions signed off by an Executive Director and regular monitoring to review their ongoing justification were identified as effective ways of addressing the problem of suspensions and special leave.

The accountability of senior leaders

A number of the seminar participants who had negative experiences of raising concerns were unhappy that senior leaders who had been either directly or indirectly responsible for the incident that they had raised were not held accountable. We asked participants whether the new Duty of Candour and the Fit and Proper Person Test (FPPT) for directors that will come into force in November 2014 would make a difference to the accountability of senior leaders. Participants were unsure of the impact these provisions would have and highlighted that there were still many questions about how the arrangements would work in practice.

One practical proposal was that interview panels appointing senior managers and clinicians should explore candidate's experiences and insights about the raising and handling of concerns.

Confidentiality Clauses

Some participants were adamant that organisations should not be able to bind people who speak up with confidentiality clauses. There was agreement that any clauses that prevented or inhibited the NHS from learning about poor practice –patient safety, governance and investigation processes – should not be allowed. There was support for the suggestion of a standard NHS settlement agreement was also suggested.

PRIORITIES FOR CHANGE

At the end of the first three seminars we asked people to highlight the actions they felt had the greatest potential to make 'freedom to speak up' a reality in the NHS. Whilst the comments were wide ranging, four main themes emerged. By far the largest group of comments were associated with making speaking up about concerns a mainstream or normal way of working that makes an essential contribution to better care, safety and work satisfaction. The other main themes were

- The provision of support for people who raise concerns
- the accountability of Boards and senior leaders for setting the right culture and procedures and
- checks and balances such as independent adjudication and regulation.

In the final seminar we 'road tested' a some possible actions that could promote an open and honest culture by asking participants to indicate which ones had the greatest potential to make a difference and which might have limited impact. The approach was not intended to offer a scientific evaluation but it did produce some interesting insights that qualified and confirmed some of the points noted in the earlier part of the report.

Raising concerns

The actions which attracted the greatest support from participants were:

- Training in raising, logging and investigating concerns
- Team discussions about good practice and debriefings to explore emerging concerns.

The development of an open, honest and just culture was also stressed. The action identified as least likely to make a difference was a rebrand or/substitution for the term 'whistleblower'. Interestingly there were split views about the value of ambassadors and Board level leads for raising concerns.

Handling concerns

The actions that were most supported were:

- Having arrangements for fair and proportionate investigations which are only independent of the organisation where appropriate
- monitoring the welfare and experience of whistleblowers and others involved
- having a pool of people who are trained to undertake the investigation of concerns.

In contrast to the apparent support for mediation expressed in the earlier seminars people who took part in the last event had split views about its value and about the obligatory recording of concerns.

Resolution and moving on

The interventions that participants highlighted as being of greatest importance to resolution and moving on concerned individual accountability such as having fit and proper managers. Giving support to people who raise concerns to find alternative employment was also emphasised, but interestingly people were undecided about whether a guaranteed interview was the right approach. There was little support for a national repository of good practice –as noted earlier there were doubts about whether the information would be used and concerns about the burden of data collection

We asked participants to comment on the apparent dichotomy between having an open and honest culture in the NHS and the emphasis on 'holding people to account 'which had connotations of blame. Participants suggested that it is possible to differentiate bad behaviour from culpability.

People should be held to account for their honesty, for their behaviour to patients and each other, and in particular for situations where positions of power are abused. The following comment summarises very well the situation that the NHS should be aiming to achieve:

"In an open, transparent and genuinely no blame culture staff will feel safe enough to take accountability for their actions. They will be confident in acknowledging that their behaviour has been unacceptable as it will not land them in hot water and the defensive attitudes that we so often see just won't be necessary."