National Guardian
Freedom to Speak Up

Northern Lincolnshire and Goole NHS Foundation Trust

A case review of speaking up processes, policies and culture

Contents

Executive summary

In September 2017 the National Guardian's Office conducted a review of the speaking up policies, processes and culture at Northern Lincolnshire and Goole NHS Foundation Trust. We carried out this review because we had received information that the trust's support for its workers to speak up did not always meet with good practice.

We also received information that many workers had spoken up anonymously to the Care Quality Commission over a two year period, raising a variety of issues, including the existence of a bullying culture and a failure to respond to patient safety issues.

Our review's purpose was to identify where speaking up policies, processes and culture did not meet with good practice and to make recommendations to the trust on how they should remedy this. We also looked to commend examples of good practice where we found them.

The trust provided all necessary support for our review's completion, from providing all the information we asked for to working with us to promote the review among its staff and the wider public.

Our review found evidence of a speaking up culture that needed improvement, where the issues raised by staff were not always handled in accordance with good practice, including where staff had spoken up about serious patient safety matters.

We also found that policies and procedures related to speaking up needed improvement as they did not provide sufficient support to trust workers to speak up about issues.

In addition, while the trust had appointed a Freedom to Speak Up Guardian and Associate Guardians to provide independent support for staff to speak up, this service required more ring-fenced time to effectively meet all workers' needs.

Several workers also approached us to tell us about their experiences of speaking up and gave examples of where they felt the trust had not responded appropriately to their concerns. In doing so they described a bullying culture that existed in certain parts of the trust that meant that workers were often afraid to speak up.

However, it was also clear when discussing the speaking up culture in the trust with its senior leaders that several of them, including the new chief executive officer, recognised that it needed urgent improvement and they were planning a variety of steps to address this.

These steps included undertaking listening events with staff groups to learn about their issues, a plan to develop a compassionate leadership programme for senior managers and the development of an equality and diversity strategy to address matters raised by workers in the 2016 NHS staff survey.

In response to the evidence we have found we have made 23 recommendations to the trust on how they can improve their support for their workers to speak up.

With each recommendation we have indicated the time frame in which the trust should aim to implement the necessary actions and we will work with the trust to support this implementation.

In addition to our recommendations we have also commended the trust in a number of areas where we have identified that its speaking up arrangements meet good practice.

Our findings can be summarised as follows:

Areas where improvements were necessary

There was evidence that the trust's policies, processes and culture did not always support its staff to speak up. This included:

- Evidence of a poor speaking up culture in the trust where issues raised by workers were not always responded to according to good practice, including where staff had raised serious safety issues.
- Evidence of bullying in the trust, including the existence of a bullying culture within specific teams, that made workers fear the consequences of speaking up.
- Evidence that the quantity of ring-fenced time provided to the Freedom to Speak Up Guardian, as well as the number of individuals in the Guardian team overall, was insufficient to meet the needs of all workers.
- The reports submitted by the Freedom to Speak Up Guardian to the trust board lacked the necessary detail and content to ensure that the board had sufficient information about the speaking up policies, procedures and culture at the trust.
- There was no specific training for staff on either how to speak up, or for managers on how to handle matters raised by workers according to the policies and processes of the trust.
- The trust's speaking up policy did not meet national minimum standards as set out by NHS Improvement.
- The trust's bullying and harassment policy needed improvement to ensure it met the standards set out in guidance by NHS Employers.
- The trust did not have a systematic approach to measure the effectiveness of its speaking up policies, processes and culture.

Examples of good practice

We also found evidence of good practice that was supportive of trust workers speaking up. This included:

- A robust recruitment process to select staff to undertake the role of Freedom to Speak Up Guardian and Associate Guardians to support speaking up.
- The launch of a series of listening events across the trust, beginning in autumn 2017, to listen to and learn from the views of staff.
- The improvement of human resources processes to ensure they are more supportive of workers who speak up.

- The commencement of work to assess the personal professional values and behaviours of senior managers, to identify whether education and training is needed to improve and develop them.

In addition, some senior leaders were also planning to take further steps to support workers to speak up. These included:

- A plan to provide the Guardian team with additional resources.
- A plan to develop a compassionate leadership campaign in 2018 to address a bullying culture in the trust and to promote better staff engagement.
- A draft four year equality and diversity strategy to address the issues raised by workers in the 2016 NHS staff survey.

Acknowledgements and thanks

In completing this review we would like to thank the following individuals for their engagement and support:

- 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 Associate Guardians.
- Workforce Race Equality Standards Team at NHS England.
- NHS Improvement.
- NHS Employers.
- Care Quality Commission.

Introduction

The National Guardian's Office

The National Guardian's Office (NGO) was set up following the Francis Freedom to Speak Up review, published in April 2015. The review sets out 20 principles and actions to ensure that NHS workers can speak up freely at work, without fear of detriment, to create a safer and more effective service for everyone.

Principle 15 sets out the terms for the role of a National Guardian and NGO to support this work and to bring about a positive culture change in speaking up across the NHS.

The NGO provides leadership, training and advice for Freedom to Speak Up Guardians based in all NHS trusts and also provides challenge, learning and support to the healthcare system as a whole by reviewing trusts' speaking up culture and the handling of workers' issues.

The full Francis Freedom to Speak Up report can be found here.

The NGO is an independent body sponsored by NHS Improvement, NHS England and the Care Quality Commission. Further information regarding the NGO is available here.

Case reviews

As part of its work the NGO reviews how a NHS trust or foundation trust has supported its workers to speak up, where it receives evidence that this support has not 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.

The primary focus of a case review is on identifying as much learning as possible about how the speaking up arrangements and cultures can be improved. A review will also highlight any examples of good speaking up practice, including any new or innovative steps that a trust has taken to support its workers to speak up.

To conduct a case review the NGO works with the trust in question to identify relevant information and to feedback learning as it arises.

Where the NGO finds evidence during a case review that a trust's support for speaking up has not met with good practice it will make recommendations about how the trust should improve this.

We publish our case review reports on our webpages and ensure that they are shared with individuals and bodies with a direct interest in the review process. These include trust workers who have contacted us about their speaking up experiences, the trust itself and regulatory bodies with responsibility for ensuring the trust delivers care and treatment according to accepted standards.

The NGO is currently undertaking a 12 month pilot of its case review programme, which began in June 2017. At the end of the pilot the NGO will review the process to see how it can be improved.

The NGO will use all the feedback it receives during the pilot, including from individuals who have referred cases for review, to ensure that the case review process meets the needs of all workers who wish to speak up.

More information about NGO case reviews is available on our webpages.

Why we conducted a case review at Northern Lincolnshire and Goole NHS Foundation Trust

The NGO was made aware of concerns regarding the working culture at the trust following issues raised by workers to regulators, as well as a letter sent by an anonymous member of trust staff in June 2017 to the Care Quality Commission (CQC), Members of Parliament and the local press.

The letter's author, describing themselves as someone 'in a senior position in the organisation for many years', stated that 'senior managers like myself feel compromised, bullied and afraid to speak out' and that where workers had spoken up the trust had 'swept [them] under the carpet and filed [them] into the difficult to handle tray.'

In response, a senior trust leader speaking at a public meeting held to explain to the local community how the trust intended to improve its performance, expressed regret that the letter had been sent. They further commented that the trust faced significant challenges, had been placed in special measures by regulators and the issues raised in the anonymous letter was indicative of those challenges.

Twenty four workers had also spoken up to CQC inspectors over a period of 18 months prior to our case review, raising a range of issues, including a bullying culture in the trust, an inability to learn from incidents and a failure to support workers to speak up.

In addition, CQC inspectors who assessed the trust in October and November 2016 reported a number of concerns regarding the speaking up culture at the trust, including a 'fear among some staff groups regarding repercussions of raising concerns and bullying and harassment.'

Further, the results from the 2016 NHS staff survey indicated that the percentage of staff expressing confidence in the fairness and effectiveness of procedures to report incidents, errors and unsafe clinical practice was lower than the average across other NHS trusts.

This evidence of workers' concerns prompted the NGO to undertake a fact finding visit to the trust, in August 2017, along with staff from NHS Improvement, to learn more about the speaking up culture. Following this visit and because of the concerns raised we decided to undertake a wide-ranging review of how the trust was supporting its staff to speak up in relation to the principles of good speaking up practice, as set out in the Francis review.

How we conducted our review

We visited the trust on two occasions during September 2017 to meet with trust staff at all levels to discuss their experiences of speaking up and the working culture. We asked trust leaders about how they intended to support their workers to speak up and specifically to address the matters described above, in respect of the alleged existence of bullying and the reported fear of many staff to speak up.

We visited all three trust hospital sites, at Goole District Hospital, Scunthorpe General Hospital and the Diana Princess of Wales Hospital in Grimsby. During those visits we met with a total of 37 employees of the trust, including the CEO and other members of the trust board, as well as nurses, doctors and ancillary staff. As well as one to one meetings on site, workers were able to contact the NGO via a dedicated email address to discuss their speaking up experiences.

In addition, we met with the trust's Freedom to Speak Up Guardian and Associate Guardians to learn how they supported staff to raise issues and to discuss whether the trust provided them with adequate resources, ring fenced time and support to undertake this role.

At each site we also held staff forums for workers to tell us directly about their experiences of the speaking up culture in the trust. Unfortunately, despite the advertising of the forums in advance across the trust, a total of only five workers attended.

To promote the case review and the staff forums the NGO worked with the trust to devise publicity materials, including posters and messages for internal staff communications that were sent to staff in advance of the commencement of the review.

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

Where we found issues we promptly raised them with trust leaders to allow them to address them as quickly as possible.

Recommendations and actions

Where we found evidence that the trust's support for speaking up was not in accordance with good practice we have made recommendations as to how the trust should remedy this.

A list of our recommendations is set out in the Annex to this report.

Where the trust has already begun to take steps to address our recommendations we have stated this. We have also asked the trust to produce an action plan in response to our recommendations and we will publish this once we receive it.

We will work with trust staff, including the trust's Freedom to Speak Up Guardian and Associate Guardians, to support the trust's implementation of their action plan.

To support the trust to implement our recommendations we will advise regulators of the actions the trust are taking in response, to ensure the trust receives all appropriate guidance to complete this work.

The structure of this report

We have set out the information we gathered during our review under four main headings based on those used in the Francis Freedom to Speak Up review, namely culture, the handling of concerns, supporting good practice and vulnerable groups.

We decided which areas to look at in relation to speaking up according to the information we had received about the trust before beginning our review.

We set out our recommendations relating to each of these four areas under relevant sub-headings.

About the trust

Northern Lincolnshire and Goole NHS Foundation Trust has three hospitals, Goole District Hospital, Scunthorpe General Hospital and the Diana Princess of Wales Hospital in Grimsby, which have a total of 850 beds between them. The trust provides hospital and community services to over 350,000 people across North Lincolnshire and the East Riding of Yorkshire, and employs approximately 6,500 staff.

The trust was formed in 2001 and was awarded foundation status in 2007. A foundation trust is different from an ordinary NHS trust because it has more freedom to manage and provide its services and is accountable to local people, who can become members and governors of the trust.

The trust was most recently inspected by the Care Quality Commission (CQC) in October and November 2016 and received an overall rating of 'Inadequate'. During this inspection the CQC assessed services provided at the Scunthorpe and Grimsby hospitals, but not in Goole as inspectors had previously rated services in this hospital as 'Good' overall in October 2015. Inspectors also rated caring overall in the trust as 'Good'.

According to the CQC's inspection process the category of work related to how the trust supports its workers to speak up is defined as 'Well Led'. The CQC rated how 'Well Led' the trust was as 'Requires Improvement'. A link to the inspection report can be found here.

As a result of the 2016 inspection the CQC placed the trust in 'special measures'. The commission places trusts in special measures where it has identified serious failures in the quality of care and where there are concerns that the trust's management cannot make the necessary changes without support.

This was the second time the trust had been placed in special measures, the first being in 2013. It was taken out of special measures in 2014, having made improvements.

More information about special measures can be found here.

Our findings

1. Culture

Safety culture

Policies and procedures

Some of the most important issues that workers can raise when speaking up relate to patient safety matters. Therefore, an essential element to a positive speaking up culture is policies and procedures that support workers to do this.

However, information received by the Care Quality Commission (CQC) from some workers at the trust described a culture where staff did not always feel free to speak up about safety concerns, lessons were not always learned from incidents and that staff were not always informed of any actions taken following the investigation of incidents.

We also noted that the most recent CQC inspection report, published in April 2017, identified that 'the trust must ensure that, following serious incidents … lessons learned are identified and shared with staff …'

We therefore looked at the trust's policy for dealing with serious incidents and the policy and procedure for reporting to see if they were supportive of workers who wished to speak up about safety matters. Both policies were comprehensive, and contained passages highlighting the need to learn from events, rather than blame individuals and to support staff involved in incidents. The incident reporting policy also advised managers to feedback to staff who had reported them.

However, although the policy for dealing with serious incidents made reference to sharing learning it did not specify that this should be done with any worker who had spoken up to raise the matter. In addition, while both policies made reference to the support available for staff when reporting or dealing with incidents, neither policy made any reference to the trust's Freedom to Speak Up Guardian, Associate Guardians, or its speaking up policy. A trust leader informed us that the policies would be amended to incorporate a reference to the Guardians.

In terms of procedure, the trust employed an electronic system widely used across the NHS for reporting incidents on which all staff were trained and which was frequently used. It had also made an adaptation to the system to allow staff who recorded an incident to indicate whether they wished to receive feedback on how the incident was responded to. This was an example of good speaking up practice.

Because the CQC's latest inspection report, referred to above, required the trust to ensure that lessons are learned learn from incidents we have not made any recommendations in this regard.

Recommendation 1

Within 3 months the trust should revise its policies and procedures relating to the reporting and handling of incidents to ensure they refer to the support available for staff to do this from the trust Freedom to Speak Up Guardian and Associate Guardians.

Recommendation 2

Within 3 months the trust should revise its policy for dealing with serious incidents to ensure it provides that feedback and any learning should be shared with staff who had spoken up regarding an incident.

Leadership and culture change

We asked some trust leaders for their views on the safety culture in the trust, whether they thought staff were appropriately supported to speak up about safety concerns and, if not, what steps they would take to address this.

Several leaders said that systems, policies and procedures were in place to ensure that staff appropriately reported safety incidents and were supported to do so. In addition, they said the trust was taking steps following the recent CQC inspection report to ensure that learning from incidents was identified and implemented on each occasion. CQC inspectors confirmed to us that the trust had put action plans in place to do this.

However, one senior leader conceded that the trust faced a common challenge when compared with other parts of the NHS, as well as other sectors, where trust workers did not always feel free to speak up about safety or other matters without fear of criticism for having done so, from peers and colleagues within their own teams. They further observed that an important factor in addressing this challenge was to improve clinical leadership across the trust.

The observations of the senior trust leader regarding the trust's safety culture were reflected in some of the experiences workers shared with us that we have set out below, and have informed our recommendations to address speaking up in relation safety issues.

Culture of raising concerns

Policies and procedures

The trust had a speaking up policy ('Speaking Out Policy & Procedure') to support staff to speak up.

When evaluating whether a trust's policy is in accordance with good practice we refer to the minimum standards set out in the speaking up policy for the NHS published by NHS Improvement in April 2016.

This guidance can be found here.

While the trust had taken steps to improve and update their policy in July 2017 there were still areas where it needed to do more to support good practice. These areas included:

- There was no reference in the policy to the Freedom to Speak Up Guardian or the Associate Guardians. This was a significant omission as the Guardian's role, in accordance with the trust's contract with NHS England, is to support staff to speak up. The trust had also appointed the Guardian seven months before revising the policy.
- The policy made reference to the fact that the trust would only support workers who spoke up 'in good faith'. This is an out of date reference to a previous legal requirement under the Public Interest Disclosure Act 1998 that was removed in 2013 and provided a restriction on speaking up.
- The policy informed workers that they could speak up to bodies outside the trust, such as the Care Quality Commission or Parliamentary and Health Service Ombudsman only 'if [they] have fully exhausted internal procedures'. This places an improper restriction on speaking up and is not in accordance with good practice.

We raised these issues with a senior trust leader, who responded that the trust would revise its speaking up policy once it had received the NGO case review report, to ensure the policy's contents reflected the learning and feedback from the report.

No information was available regarding how the trust would ensure that all workers were aware of the new policy.

Recommendation 3

Within 3 months the trust should revise its current speak up policy to ensure that it is in accordance with good practice and reflects the minimum standards set out in the NHS Improvement speaking up policy for the NHS.

Recommendation 4

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

Recommendation 5

Within 12 months the trust should begin work to ensure that, upon the scheduled review of any trust policy and/or procedure, the policy or procedure in question is in alignment with good practice in relation to the freedom to speak up.

Senior leadership and culture change

There was evidence that some workers did not think that the culture in the trust was supportive of speaking up. In the NHS 2016 staff survey, the percentage of staff at the trust expressing confidence in the fairness and effectiveness of procedures for reporting errors and incidents compared poorly with other acute trusts in England, being in the lowest 20%.

In addition, over a period of 18 months prior to our review in September 2017, 24 workers anonymously reported to the Care Quality Commission that the culture in the trust was not supportive of speaking up and that their concerns about a range of issues were often ignored by managers.

We asked senior leaders for their view of the speaking up culture and several expressed the view that it needed to be improved and that it did not provide a supportive environment where workers were always free to speak up. Comments ranged from a description of the speaking up culture as 'very poor' and 'deeply unhealthy', where workers were often afraid to speak up because of 'an autocratic management style', to concessions from many of the senior leaders that all staff required improved training on the raising and handling of issues raised by staff.

At the same time many also stated that they were committed to improving the speaking up policies, processes and culture and said that although this work would take time, it was beginning to happen. Several of them, including the chief executive, were recently appointed at the time of our case review and expressed a desire to bring about change.

We asked what specific steps the trust's leadership was taking to deliver a positive change to the trust's speaking up culture. All those we spoke to cited the trust's appointment of a Freedom to Speak Up Guardian and Associate Guardians to provide independent support for workers to speak up as a positive step. The role of the Guardian is discussed further below.

The leaders also said that they would be assessing the feedback obtained from a variety of recent staff surveys and other engagement events, to determine how to improve the speaking up culture. These included Listening into Action events, as well as the NHS 2016 staff survey.

Senior leaders also identified steps to tackle an historic bullying culture in the trust that was a clear obstacle to a positive speaking up working environment. This is discussed further below.

In addition, the trust had appointed a non-executive director to have responsibility for overseeing the trust's speaking up policies, procedures and culture. This was in accordance with good practice, as referred to in the speaking up policy for the NHS published by NHS Improvement.

However, at this stage, there is no clear vision among the trust leadership as to how to deliver this change. Ensuring that good speaking up practices and cultures are embedded in the work of a large organisation such as a NHS trust requires an articulated vision of how the trust leadership intends to support its workers to speak up, containing coordinated actions across a diverse range of activity, from training and staff engagement to policy making, governance and HR practices.

Other NHS trusts have drawn up such strategies, often using the principles based in the Francis Freedom to Speak Up Report as a set of standards and objectives.

Therefore, while it was clear that there were new leaders in the trust who wanted cultural change so that all staff felt free to speak up, there remained a need to create a clear strategy to help deliver this objective.

Recommendation 6

Within 6 months the trust board should articulate a vision of how it intends to support its workers to speak up, which encompasses a strategy containing deliverable objectives within fixed timescales and under appropriate executive oversight, and to effectively communicate this to trust workers.

Measuring the effectiveness of speaking up processes

We asked senior leaders how they intended to measure the effectiveness of the trust's speaking up policies, processes and culture, to ensure that these met the needs of workers and to ensure planned improvements met their objectives.

In response, trust leaders said they would use the information provided by the Freedom to Speak Up Guardian and the Associate Guardians relating to the issues they were supporting workers to raise and data relating to the handling of incidents to learn how effectively the trust responded to workers who reported them as well as data from staff surveys to learn how confident workers felt about speaking up.

There are other sources of information that could be used to measure the effectiveness of freedom to speak up arrangements, including:

- Number of issues raised to the Freedom to Speak Up Guardian, the themes related to those issues and feedback on how the trust responded to them.
- Staff survey results.
- Bullying and harassment reports.
- Grievance cases brought by workers.
- Staff exit interviews.
- Trust staff retention figures.
- Data relating to staff suspensions, the reasons for them and information relating to how many of these related to instances of workers also speaking up and how those workers were supported to speak up during their suspension.
- Learning identified from rulings from employment tribunals involving staff.

We asked two senior leaders whether they would consider using other data sources. Both agreed that it was something the trust could and should do. Both leaders acknowledged that the trust needed to make better use of the data it gathered and one of them observed that 'quality assurance is a new area for the organisation'.

Recommendation 7

Within 6 months trust leaders should identify and employ a range of appropriate measures to monitor speaking up processes and culture within the trust, to ensure they are responsive to the needs of all workers and are developed in accordance with good practice.

Culture of valuing workers

There was evidence that the new trust leadership was beginning to take steps to seek the views of its workers in order to improve the working culture and processes in the trust.

From the autumn of 2017 trust leaders had planned a series of staff engagement events as part of the 'Listening into Action' programme – a model used by other NHS trusts. The programme's purpose is to formally engage with different staff groups in order to learn about how they want to change and improve their work and how they believe the obstacles to achieving that improvement can be removed.

This formalised engagement with workers, leading to action plans to implement their ideas and address their concerns, can complement the work undertaken by Freedom to Speak Up Guardians, who provide ongoing support for staff to speak up and whose regular reports to their boards about the issues they support workers to raise should inform executives' plans to improve the working environment.

More information about the Listening into Action programme can be found here.

Nevertheless, we also found evidence that there was still much work to be done in this regard, including examples where trust leaders had not listened to staff who had spoken up, including in relation to important safety issues and the existence of a bullying culture.

This information is discussed below.

Culture free from bullying

Policies and procedures

We reviewed the trust's bullying and harassment policy and procedure against bullying and harassment guidance for trusts issued by NHS Employers.

This guidance is available here.

The trust's policy and procedure met many of the standards set out in the guidance, including a clear statement that the trust would not tolerate bullying and harassment and would protect any employee who made a complaint under the policy from victimisation.

However, there were areas where the trust's policy and procedure was not in accordance with the guidance. These included:

- No reference to what measures the trust would take to prevent bullying and harassment
- No timescales given for action in response to such behaviour
- No reference to the responsibilities of HR staff
- No reference to any staff training

Recommendation 8

Within 6 months the trust should ensure that its bullying and harassment policy and procedure is consistent with the standards set out in the bullying and harassment guidance issued by NHS Employers, including how the trust will implement and monitor the revised policy and ensure its contents are shared with all staff.

Leadership and culture change

As already mentioned, there was evidence of a bullying culture in the trust. This was reflected in the CQC inspection report published in April 2017. In that report the Commission required the trust 'to take actions to ensure that staff could raise concerns without fear of negative repercussions.'

We also had information that several members of staff had anonymously reported to the CQC the existence of a bullying culture in many areas of the trust.

As referred to above, a senior manager had also anonymously spoken up to the local press in June 2017, alleging the existence of a bullying culture affecting many staff, including senior managers who were 'compromised, bullied and afraid to speak out.'

The 2016 NHS trust staff survey confirmed the existence a bullying culture, identified by the same survey as regrettably common across many trusts, with 25% of trust staff who responded stating that they had experienced bullying or harassment from colleagues in the 12 months prior to the survey. This figure was the average for all NHS trusts in England and had remained unchanged from the 2015 trust survey.

Three workers who approached us during our review to tell us about their experiences of speaking up in the trust alleged that they had experienced bullying. We describe their experiences below in our case studies.

We asked the trust's senior leaders about this evidence and what steps they were taking to address it. Several leaders acknowledged that a bullying culture existed. Whilst one senior leader indicated that training to address potential bullying behaviour was not currently available, another said that the trust intended to launch a programme of work to address this, at the beginning of 2018, although there was no detailed information available on this programme at this time.

The trust also planned to launch a 'compassionate leadership' campaign in early 2018, the purpose of which was to train managers in best practice when engaging with staff. At the time of our review the trust was taking advice on how to deliver such a programme from a variety of sources, including other NHS trusts.

In addition several leaders also highlighted work the trust had recently undertaken to assess the personal professional values and behaviours of senior managers, to identify whether education and training was needed to improve and develop them.

They said this work was important in relation to bullying and harassment, as severe staffing shortages across the trust could create significant stresses within the working environment that contributed to an undermining of behaviours and values, although they also emphasised that such shortages did not excuse such behaviour.

In contrast with these observations regarding the need to improve the culture and the plans to achieve this, one senior leader said they did 'not accept that bullying is an issue in the organisation' and that, in their experience, staff rarely formally raised it as an issue.

Recommendation 9

Within 12 months the trust should take steps to address bullying behaviour, including training for all staff relating to the awareness and handling of such behaviour.

2. Handling concerns

During our case review individual workers from the trust approached us to share their experiences of how the trust had handled specific concerns they had raised.

For each case we looked into we have provided a short case study below with, where appropriate, recommendations.

As with all the narrative in this report there are no references to individuals who have spoken up to us in order to protect their identity and to ensure that the focus of this case review is on learning how to improve speaking up culture, policies and procedures.

In each case we asked the workers who approached us if they consented to us raising their case with the trust. We received this consent in all cases except case study four, where staff declined to give their consent saying they feared they might experience negative consequences if we asked trust leaders about the handling of this case.

Case study 1

A senior member of staff informed us that they had concerns about how the trust had responded to their speaking up.

They explained that they and other colleagues had spoken up about the culture of bullying and harassment that existed in their department, where they alleged that senior managers sought to 'silence differing views', causing staff to become disengaged and fearful of speaking up.

They said that they and their colleagues had also spoken up about the continued failure across the trust to take appropriate steps to learn from serious incidents.

The staff member told us that workers had first raised these issues with external agencies such as the Care Quality Commission, rather than within the trust, because they were 'worried about reprisals' from colleagues.

Following the raising of these concerns the staff member told us a senior leader criticised them for doing so, saying that speaking up about these matters was simply 'interfering'.

The staff member told us they then raised further issues within the trust, including concerns regarding the alleged manipulation of patient safety data. In response, the staff member alleged they were accused by a senior trust leader of 'undermining' colleagues by making these allegations.

The staff member said that the trust did not inform them of what action they took in response to the issues they had spoken up about, including whether they had been investigated, or the outcome of any such investigation.

With the staff member's consent we discussed their speaking up case with the trust. In response, a trust leader told us that the trust had conducted a full investigation into all the allegations, including in relation to the patient safety data and found no evidence to support them. They added that they then fed these findings back to the staff member.

With regards to the bullying culture described, as well as the dismissive comments of the trust leader in response to the allegations, the trust leader conceded that the speaking up culture in the staff member's department, as well as others in the trust, needed to be improved and that the trust was planning to do this in 2018 through its compassionate leadership campaign. They also expressed regret at the comments and attitude expressed in response to the original allegations.

Sometime after speaking up the staff member who spoke to us was themselves the subject of an investigation, following allegations made against them by colleagues regarding their conduct. They told us that the allegations were without foundation and, in their opinion, were motivated by the hostility of colleagues because the issues about which they had originally spoken up reflected badly on those colleagues.

An investigation into the allegations was ongoing at the time of our review.

We asked the trust leader about the staff member's perception that malicious allegations had been made against them because they had previously spoken up. In response, the leader said that it was necessary to ensure that staff who spoke up were not subject to detriment and the investigation into the allegations against the staff member, while not yet complete, had looked for evidence of any malicious motive, but had not found any.

The leader added that all investigations into allegations against workers would look for such evidence, with appropriate action being taken where evidence of malicious allegations was found. However, we noted that the trust disciplinary policy did not direct that investigations should look for such evidence.

Because it is essential to developing a positive speaking up culture that a trust takes all appropriate steps to protect individuals who speak up from experiencing detriment we have made a recommendation that it continues this approach to investigations.

Recommendation 10

Within 6 months the trust should continue to ensure that all investigations into the alleged conduct of workers who have previously spoken up also seek to identify whether any such allegations are motivated by a desire to cause detriment because that worker spoke up and, where such evidence is found, take appropriate action. This should include amending the trust disciplinary policy to require such action.

Case study 2

A worker told us that they believed there was a 'bullying culture' in the trust and, over a two year period, said they had been the victim of such behaviour from a more senior member of staff.

The worker alleged that the senior staff member would isolate and undermine them and that their behaviour had a damaging impact on their health, resulting in them going off sick with work-related stress.

Following the worker speaking up about the bullying, trust managers sought to resolve the matter through mediation, but this was not successful and the bullying continued. Greater use of mediation to resolve disputes was a recommendation made in the Francis review so, whilst it was not successful in this case, we commend the early use of this intervention as a positive attempt to resolve the issue.

The worker said they then raised a formal grievance about the behaviour of the senior colleague. However, they said that the investigation into their grievance did not interview key witnesses. Following a further review of the grievance, the worker was told that there was insufficient evidence in support of their allegation.

Unhappy at this outcome the worker raised a second grievance, this time against the trust for the failure to deal appropriately with the bullying grievance. The worker said the trust HR department did not respond to this second matter for several weeks.

With the worker's consent we raised how this case was handled with a senior trust leader. In response, they conceded that the original investigation was flawed because of the failure to interview key witnesses. The leader said the trust recognised the response to the worker's speaking up should have been better and, consequently, they were investigating the case again and would report the outcome to the worker shortly.

Case study 3

A member of staff told us they were concerned about the behaviour of a senior manager in their department who they alleged had created a 'toxic work environment.'

The staff member said that the manager would shout, swear and talk condescendingly to colleagues, making it clear to them that they should not speak up about problems in the department. They alleged the manager's behaviour resulted in many staff being too afraid to speak up, with many going off sick, or leaving the department altogether.

The staff member further alleged that the manager was putting pressure on workers to manipulate waiting lists to meet targets. They claimed that the manager criticised the staff member for not bending the rules themselves so that targets could be met.

On multiple occasions the member of staff said they had spoken up about the bullying and harassment, as well as the pressure to manipulate waiting lists, to HR staff and directors in the trust, but they said that neither staff in the HR department, nor trust directors responded to the concerns by initiating investigations into them.

The individual explained that they finally decided to speak up to the Care Quality Commission and, as a result of this action, the trust finally decided to begin investigating some of the matters described.

The individual told us that they were not aware of the existence of a Freedom to Speak Up Guardian in the trust, although the Guardian had been in post at the time of some of the events described. The staff member explained that they had not seen the role advertised anywhere, or had seen any reference to it in any trust policies.

As referred to earlier in this report, we did not find any reference to the role of Guardian in the trust's speaking up policy. We also recommend later in this report that the trust should take additional steps to properly advertise the role of Guardian and Associate Guardian to all trust workers.

With the consent of the worker concerned we raised their case with a senior trust leader. In response the leader said the trust had commissioned an external, independent investigation into the allegations regarding the manipulation of waiting time data and no evidence was found of such behaviour.

The leader also acknowledged, however, that the trust had not investigated the allegations regarding the manager's behaviour sufficiently thoroughly and that a second investigation was now taking place that would be more robust. This investigation had not concluded at the time of our review.

Recommendation 11

Within 3 months the trust should ensure that, in accordance with its own policies and procedures and in accordance with good practice, all managers and leaders responsible for handling speaking up provide feedback to every individual who raises an issue, including any actions they intend to take in response.

Case study 4

Staff at the trust told us that they became concerned about particular practices and procedures that they believed were causing a significant risk of harm to many patients.

They said that although they had spoken up about these concerns to senior trust managers over a period of many months no action was taken to address them. They also said that, in response to a worker raising these issues, one senior trust leader told them 'not to concern themselves' with these issues.

Staff explained that they believed there were a number of reasons why these safety issues had arisen and why there had been a failure to investigate them. Firstly, that a senior leader in the trust had made it clear that they 'did not want to hear bad news.' This meant that some issues were ignored and clinicians felt disengaged.

Staff also alleged that the trust's governance processes were inadequate. They explained that the committee with oversight for the issue about which they were speaking up did not have the power to compel change.

However, staff explained that they had recently received support from the trust's Freedom to Speak Up Guardian and Associate Guardians to raise the patient safety issue with the trust's board and new chief executive. As a result this led to the trust taking appropriate action to address the concerns originally raised by staff.

Although it was clear from the evidence that the trust was addressing the serious safety issues raised it was also evident that the response to staff speaking up about these matters was initially too slow. The failure to appropriately investigate the concerns when first raised by staff was a breach of the trust's own policies and procedures.

Recommendation 12

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, including, where appropriate, investigating matters that are raised.

3. Supporting good practice

Speaking up training

An essential aspect of good practice is training to ensure that all workers know how they can speak up and have awareness of the sources of support to enable them to do so.

Most importantly, training should be tailored to meet the needs of staffing groups, especially for those with responsibility for responding to staff who speak up in accordance with good practice, policy and procedure.

However, the trust did not provide such speaking up training for its workers. Instead, workers were informed of the existence and purpose of the trust speaking up policy during their induction process when beginning employment at the trust. Although policy awareness is important, good speaking up practice also requires workers to have the skills and knowledge to speak up, and respond to those who speak up, well.

When we asked staff during our review whether they thought that training would be supportive, all responded that it would, including senior trust leaders.

One senior trust leader also commented that speaking up training should be linked with training on bullying and harassment, so that workers know 'what their rights are when such behaviour takes place'.

Recommendation 13

Because of the particular needs of the trust to improve its speaking up process and culture it is recommended that, within 12 months, the trust should provide all workers with mandatory, regular and updated training on speaking up, including for those with responsibility for handling concerns. This training should be in accordance with NGO guidance and the trust should monitor that it is effective.

Freedom to Speak Up Guardian

In accordance with their standard contract with NHS England all NHS trusts must appoint a Freedom to Speak Guardian, whose role is to provide support for workers to speak up.

The National Guardian's Office provides trusts with guidance on how the Freedom to Speak Up Guardian role should be supported, including advice that:

- Guardians should be appointed following a fair and open process
- Trust leaders should meet regularly with their Guardian and ensure that the Guardian has regular and unfettered access to all senior staff
- Guardians should present regular reports in person to their trust boards
- Trusts should provide sufficient resources for Guardians to be able to meet the needs of trust workers

The full details of this guidance are available here.

Although the trust was contractually required to appoint a Freedom to Speak Up Guardian by October 2016 it only did so in January 2017, when it recruited both a Guardian and three Associate Guardians whose function was to support the Guardian.

However, at the time of writing this report, two of the Associates had resigned their position, leaving one Guardian and one Associate in place.

Although the appointment was late, the trust, in accordance with the guidance set out by the NGO, undertook a robust, open and fair recruitment process for all four posts. This included a union representative on the interview panel to help provide assurance that the needs of workers were properly considered when making the appointments.

The Guardian and the Associate were trust employees and undertook their respective roles in addition to their other responsibilities. The trust provided resources for the Freedom to Speak Up Guardian to work in the role for four hours per week. The Associate Guardian worked as a volunteer, in addition to their ordinary working hours.

The Freedom to Speak Up Guardian and the Associate Guardian had regular access to senior trust managers and leaders to raise issues they were supporting workers to speak up about. In addition, there was evidence that the response of managers and leaders to those speaking up issues involving the Guardian and the Associate was positive and resulted in appropriate action.

The Guardian provided regular reports to the board on the types of issues they were supporting staff to speak up about, how the matter was handled and whether there were issues relating to speaking up that senior leaders needed to address.

However, there was evidence that the trust needed to make improvements to how the Guardian role is implemented. Firstly, the trust only paid the Guardian for a total of four hours per week to undertake their duties and, as a volunteer the Associate Guardian had no ring-fenced time at all to perform their role and had to fit this work in with their full time responsibilities.

Moreover, both the Guardian and the Associate had the responsibility of providing support to workers over a wide geographical area, covering three hospital sites in Goole, Scunthorpe and Grimsby, as well as trust services in the community. Therefore, it appeared that both the paid time available to the Guardian, combined with the total coverage that could be provided by a two-person team was insufficient to meet the needs of workers.

When we raised this issue with a senior trust leader they said that the board was considering the matter of how much ring-fenced time they should allocate to the guardian role and whether they should appoint new Associates to support them, but at the time of writing this report the board had not made any decision in this regard.

Secondly, the three reports submitted by the Guardian to the board seen by our case review team were very short and light on detail. Guardians' written reports to their boards, which they should deliver in person, are an essential part of their role. They should provide details regarding the numbers of cases they have supported workers to raise, the themes arising in those cases and how the trust responded to them.

Importantly, Guardian's written reports should also identify any barriers to speaking up in the trust, proposals for how these can be removed and an update regarding how any such work is proceeding.

The reports therefore should provide boards with a detailed insight into the speaking up culture in their trust as a whole, how well the processes and policies to support speaking up are functioning and what, if any improvements need to be made. In doing so, they will also provide an important indicator as to the quality of service and staff engagement in the trust.

When we raised this with a senior trust leader they acknowledged that such reports were very short and said that the Guardian would be provided with 'dedicated administrative support' from the beginning of 2018 to ensure that their work could be completed appropriately. At the time of our review it was not clear how much administrative support would be made specifically available.

While we endorse all support provided for guardians to undertake their duties we would strongly advise that Guardians write their own reports to ensure that the confidentiality of those workers they are supporting is not undermined by the sharing of this work.

Thirdly, the Freedom to Speak Up Guardian had not submitted a quarterly data return to the National Guardian's Office in November 2017, as requested from all trusts, detailing the number and types of cases Guardians had supported workers to raise. This is another important function of the Guardian.

Fourthly, neither the Freedom to Speak Up Guardian, nor any Associate had attended any regional meetings of Guardian peers since their appointment in January 2017. These are important quarterly meetings where Guardians share and learn good practice on how to effectively carry out the role and provide each other with advice and support on how to do this.

Finally, the trust had not taken sufficient steps to promote the Guardian role to all its workers. Although the appointments were completed in January 2017 the trust only formally announced them to its workforce in April 2017 and had not put in place any plan to promote it before that point. When we pointed out to trust leaders that this delay did not support the speaking up process they acknowledged that more should have been done to communicate the roles sooner.

In addition, while posters were displayed across the three trust hospitals that encouraged staff to speak up and how they could do so, none of them made any reference to the existence of the guardian roles.

We asked 26 staff across all three sites whether they knew about the role of Guardian and Associates and, if they did, whether they knew their identities and how to contact them. In response, 12 replied that they had heard of the roles and of those 12 eight workers said they knew any of the workers who undertook them, or how to contact them.

We asked a senior trust leader about how the trust assured itself that workers were aware of the Guardian role. They replied that information about the role would be shared via managers to all staff in team meetings.

Recommendation 14

Within 3 months the trust should allocate sufficient ring-fenced time for the Freedom to Speak Up Guardian and any Associates to ensure they can appropriately support the needs of workers to speak up.

Recommendation 15

Within 3 months the trust should take appropriate steps to ensure that the role and names and contact details of the Freedom to Speak Up Guardian and Associate Guardians are promoted to all workers across all three trust hospital sites.

Recommendation 16

Within 6 months a communications and engagement strategy should be developed to promote the Freedom to Speak Up Guardian and Associate Guardian's role, and to evaluate the impact it is having, in the longer term. This should include strategies to provide feedback on actions taken in response to speaking up and actions to tackle barriers to speaking up.

Recommendation 17

Within 3 months the Freedom to Speak Up Guardian should ensure that their regular reports to the trust board are sufficiently detailed and comprehensive to support the development of a positive speaking up culture.

Recommendation 18

Within 3 months the Freedom to Speak Up Guardian and any Associate Guardians should begin regular attendance at regional meetings of their peers to ensure that they have access to guidance and support to undertake their work, including to assist with the writing of board reports and in order to share learning and good practice with them.

Human resources procedures

We looked at the Human Resources (HR) processes and procedures of the trust because HR teams often play an important role in the speaking up process. This is because workers often speak up to their HR colleagues about matters relating to their working conditions, their relationships with their colleagues, or their colleagues' conduct.

Because of the frequency with which this is the case we would remind HR staff in all NHS trusts to assure themselves that the processes they use ensure that potential patient safety or similar issues that are raised as part of a disciplinary matter are appropriately considered and investigated, and that the person raising those issues is given appropriate support as someone who is speaking up

There was evidence that the trust's HR processes and procedures were not fully supportive of speaking up. Firstly, although senior staff maintained that workers suspended as part of an HR investigation into their conduct could access the Guardian team during their suspension, the letter sent by the trust to suspended workers made no mention of this fact.

When we raised this with a senior trust leader they undertook to amend the standard letter for suspended staff as soon as possible.

Secondly, we also saw that the trust's HR department did not always consider the substance of the disciplinary cases it was investigating in the round, and therefore could not assure itself whether potential patient safety or similar issues that were involved in a case it was dealing with were being properly investigated, or the person raising the issue was being appropriately supported.

When we asked a senior trust leader about this they said that they would take steps to address this.

The senior leader added that the trust was committed to ensuring that its HR procedures were more effective in supporting the needs of workers who spoke up.

In addition to the actions stated above regarding suspension letters and process, the leader said that the trust had recently appointed a new HR case review manager to oversee all HR cases and this role would specifically include liaising with the Guardian and their Associates to ensure staff who had spoken up and who were going through HR process were appropriately supported, and the matters they were raising were being addressed.

We commend this step as innovative practice that will help support workers' speaking up and help ensure that the issues they raise are addressed. We have included a recommendation below that relates to it because we want to see this work continue. In commending this practice we also recommend below that all HR policies and procedures are mindful and supportive of the need to respect and uphold the confidentiality of those workers who speak up.

Recommendation 19

Within 3 months the trust should ensure that all HR policies and procedures meet the needs of workers who speak up, including letters to suspended workers that accurately state their ability to access their Guardian or Associate Guardian.

Recommendation 20

Within 3 months the trust should continue its work to ensure that, where a worker is going through a disciplinary process that also encompasses potential patient safety issues or similar matters they have raised, the trust continues to provide that worker with all appropriate support to speak up about those matters and also takes all appropriate steps to maintain the worker's confidentiality.

Mediation and dispute resolution

Good speaking up practice directs that mediation services are available to support workers who speak up about the working relationships with their colleagues to help resolve such issues, providing all parties consent to participating in its use. This is because poor working relationships can be a risk to patient safety. Moreover, issues raised by speaking up may require working relations between staff to be improved.

We asked senior trust leaders about the use of mediation to resolve certain speaking up issues, firstly because we noted that its use for this purpose was not mentioned in the trust speaking up policy. Also, we noted that in the four case studies set out above there was evidence of it only being offered in one of the four cases, even though each case involved workers speaking up about their relationships with their colleagues.

Two senior trust leaders said that mediation was sometimes used, but also said that the trust could do more to make use of it, including promoting its potential value to workers. One said 'we want to use mediation in a more proactive way'. Another commented, 'we want to expand on this as part of addressing the bullying culture'. However, at the time of our review, there was no plan in place to develop the use of mediation.

Recommendation 21

Within 12 months the trust should take steps to actively promote the use of mediation, where appropriate, to resolve issues arising from speaking up.

4. Vulnerable staff groups

The Francis Freedom to Speak Up review highlighted that certain minority staff groups are particularly vulnerable when speaking up and steps should be taken to ensure that all workers were free to speak up.

These vulnerable staffing groups included those whose employment was of a temporary nature, which meant that they did not always feel fully integrated into an organisation and that they did not always receive the same levels of support as other workers, as well as student and trainee staff, who described how their junior position made them fear the consequences of speaking up.

In the case of Black and Asian Minority Ethnic (BAME) staff many from this group told the Francis review that they felt vulnerable when speaking up because being in a cultural and ethnic minority could leave them feeling excluded in the workplace. The review also reported a perception that where BAME staff speak up they are 'more likely to receive harsher sanctions and more likely to experience disproportionate detriment in response to speaking up.'

Concerns raised by Black Asian and Minority Ethnic workers

The latest available data on the trust workforce from 2016 showed that BAME staff group comprised 8.1% of the overall workforce. We looked at how the trust supported its BAME workers to speak up as there was evidence that some BAME trust workers did not feel they were treated equally or fairly.

Some of this evidence came from the 2016 NHS trust staff survey. Of those responding to the survey 9% more BAME staff than white staff said they had experienced bullying and harassment from colleagues; 16% fewer BAME respondents than white respondents said the trust provided workers with equal opportunities for staff development and 14% of BAME respondents said they were treated less favourably than white staff.

Data from the survey relating to how workers regarded the fairness of procedures to report errors and incidents indicated that a slightly higher proportion of BAME respondents than white respondents said that regarded such procedures as fair and effective. In respect of workers having confidence and security in reporting errors and incidents the proportion who said they did was identical when comparing BAME to white staff.

It should be noted that both these questions ask specifically about the 'reporting of errors, near misses and incidents' rather than speaking up in general. Therefore, while the results indicated a slightly more positive BAME response, as compared to white staff in respect of the effectiveness of such specific processes, a clearer and more concerning voice is heard in the responses relating to discrimination, bullying and harassment.

The Care Quality Commission inspectors also expressed concern regarding issues of equality following an inspection of the trust during the last three months of 2016. Their report cited that 'further work was required in ensuring equality and diversity was embedded in the trust'.
Several senior staff acknowledged that the trust survey results in relation to BAME staff were 'poor' and that the trust needed to take action to address this, including the needs of the many BAME doctors in the trust.

However, not all senior leaders we spoke to identified that there were any concerns among the BAME workforce. One executive said over many years at the trust they had not been 'aware of any issues about this'.

Meeting the needs of Black Asian and Minority Ethnic workers

In response to the survey results, senior trust leaders told us they were developing a four year equality strategy to address the issues identified in the survey, as well to ensure that the trust was compliant with its statutory obligations in relation to equal treatment of staff in the workplace. Trust leaders said they hope the board would approve the strategy by December 2017. At the time of writing this report, a final strategy had yet to be finalised.

The trust had also appointed an equality and diversity lead in March 2017 to oversee work in improving the trust's support for its minority workers.

One trust leader observed that staff 'engagement is the key … staff must not be fearful of coming forward ... we must give the minority groups a voice'.

In addition, they said that the Freedom to Speak Up Guardian was also a BAME worker, which, they hoped, would encourage BAME workers to speak up. The leader said the trust also planned to develop a BAME network to allow BAME workers to meet and raise issues and that it was going to ask the Freedom to Speak Up Guardian to chair it, although at the time of writing this report this had not yet happened.

The Freedom to Speak Up Guardian confirmed that many BAME workers had approached them with issues, however they added that many of them asked only to do so informally and did not want to be identified in any formal raising of issues. The Guardian explained that the reasons for such requests were mixed and agreed that work needed to be done on learning why this was the case.

We make a recommendation in relation to identifying obstacles to speaking up for vulnerable staffing groups below.

A trust leader also told us that more work needed to be done to train managers across the trust in equality and diversity. They observed that current training was neither detailed enough, nor mandatory for managers and was 'only just scratching the surface'.

Another senior member of staff commented that the trust needs to do more to ensure that the trust's policies and procedures supported the needs of minority workers. They said that this should be assured by undertaking a robust equality impact assessment in respect of all trust policies, but said that currently the assessments that had been done were just 'a box-ticking exercise' and needed to be improved.

Help is available for trusts to support the needs of their BAME staff from the Workforce Race Equality Standards implementation team at NHS England. Once a trust identifies that they need assistance to support their BAME staff, they can request help from the team, who will look at a range of relevant data, including staff surveys and help develop action plans to address these issues.

Given there is evidence that the trust is already taking action to improve its support for its BAME workers, but is still early on in this process, we recommend that the trust seeks support from this team to help address a range of issues, particularly those referred to above relating to training, staff engagement, equality impact assessments and strategy implementation.

Meeting the needs of other vulnerable staffing groups

As discussed above, the Francis Freedom to Speak Up review identified several staffing groups that were more 'vulnerable' in respect of speaking up, largely because workers in those groups felt more at risk from the potential negative consequences from speaking up.

We asked trust leaders whether they had taken steps to identify which staffing groups were potentially more vulnerable where speaking up was concerned and what steps the trust was doing to address this. In response, they told us that the trust had not yet undertaken such work, although conceded that it was important to identify such staffing groups and any potential obstacles to speaking up they might face.

They added that such work could potentially be the responsibility of the equality and diversity lead, but this role had only been occupied for approximately six months and the person undertaking it had been focussing on other matters.

However, we would comment that the task of identifying staffing groups who may be vulnerable when speaking up is an entirely appropriate function of a Freedom to Speak Up Guardian to lead, with appropriate support from other parts of their organisation and we recommend that the trust Guardian undertakes this work.

Recommendation 22

Within 3 months the trust should consider requesting support from the NHS England WRES Implementation Team to help meet the needs of its BAME workers.

Recommendation 23

Within 12 months the trust should take all appropriate steps to identify which staffing groups in the trust feel particularly vulnerable when speaking up, why this is the case and how those groups can be supported to speak up freely and protected from any detriment for having done so.

What the National Guardian's Office will do now:

Following publication of this report we will work with interested parties to monitor the trust's implementation of our recommendations.

To do this we have asked the trust to publish an action plan within four weeks of the publication of this report to state what actions they will take. We have also sent copies of this report to NHS Improvement so that they can provide any necessary support to the trust to develop its action plan and to the Care Quality Commission so they are aware of the steps the trust will be taking to implement our recommendations.

Once the trust has published it we will then support the trust's Freedom to Speak Up Guardian to review the progress of those actions in three, six and 12 months. We will do this by meeting at those intervals with the Guardian and staff from NHS Improvement and the Care Quality Commission.

Where a review identifies that the trust has not completed the actions in its own plan we will ask regulators to address this.

We will also respond to all those individuals who have spoken to us, thanking them and providing feedback to them on how their experiences have been reflected in this report. We will ask them for feedback on their experience of how we have conducted this review.

As part of our 12 month case review pilot, we will reflect upon all the feedback we receive from this and other reviews to help us develop a process that meets the needs of all those the case review programme is intended to support.

We welcome feedback from all readers of this report. Please send your comments to:

casereviews@nationalguardianoffice.org.uk

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 and to refer any such cases to the trust and regulators.

Annex A – summary of recommendations

The recommendations arising from the case review for the trust are listed below.

They are grouped according to when we recommend the trust completes the work to implement each recommendation.

Recommendations to be implemented within three months

Recommendation 1

Within 3 months the trust should revise its policies and procedures relating to the reporting and handling of incidents to ensure they refer to the support available to staff to do this from the trust Freedom to Speak Up Guardian and Associate Guardians.

Recommendation 2

Within 3 months the trust should revise its policy for dealing with serious incidents to ensure it provides that feedback and any learning should be shared with staff who had spoken up regarding an incident.

Recommendation 3

Within 3 months the trust should revise its current speak up policy to ensure that it is in accordance with good practice and reflects the minimum standards set out in the NHS Improvement speaking up policy for the NHS.

Recommendation 11

Within 3 months the trust should ensure that, in accordance with its own policies and procedures and in accordance with good practice, all managers and leaders responsible for handling speaking up provide feedback to every individual who raises an issue, including any actions they intend to take in response.

Recommendation 12

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, including, where appropriate, investigating matters that are raised.

Recommendation 14

Within 3 months the trust should allocate sufficient ring-fenced time for the Freedom to Speak Up Guardian and any Associates to ensure they can appropriately support the needs of workers to speak up.

Recommendation 15

Within 3 months the trust should take appropriate steps to ensure that the role and names and contact details of the Freedom to Speak Up Guardian and Associate Guardians are promoted to all workers across all three trust hospital sites.

Recommendation 17

Within 3 months the Freedom to Speak Up Guardian should ensure that their regular reports to the trust board are sufficiently detailed and comprehensive to support the development of a positive speaking up culture.

Recommendation 18

Within 3 months the Freedom to Speak Up Guardian and any Associate Guardians should begin regular attendance at regional meetings of their peers to ensure that they have access to guidance and support to undertake their work, including to assist with the writing of board reports and in order to share learning and good practice with them.

Recommendation 19

Within 3 months the trust should ensure that all HR policies and procedures meet the needs of workers who speak up, including letters to suspended workers that accurately state their ability to access their Guardian or Associate Guardian.

Recommendation 20

Within 3 months the trust should continue its work to ensure that, where a worker is going through a disciplinary process that also encompasses potential patient safety issues or similar matters they have raised, the trust continues to provide that worker with all appropriate support to speak up about those matters and also takes all appropriate steps to maintain the worker's confidentiality.

Recommendation 22

Within 3 months the trust should consider requesting support from the NHS England WRES Implementation Team to help meet the needs of its BAME workers.

Recommendations to be implemented within six months

Recommendation 4

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

Recommendation 6

Within 6 months the trust board should articulate a vision of how it intends to support its workers to speak up, which encompasses a strategy containing deliverable objectives within fixed timescales and under appropriate executive oversight, and to effectively communicate this to trust workers.

Recommendation 7

Within 6 months trust leaders should identify and employ a range of appropriate measures to monitor speaking up processes and culture within the trust, to ensure they are responsive to the needs of all workers and are developed in accordance with good practice.

Recommendation 8

Within 6 months the trust should ensure that its bullying and harassment policy and procedure is consistent with the standards set out in the bullying and harassment guidance issued by NHS Employers, including how the trust will implement and monitor the revised policy and ensure its contents are shared with all staff.

Recommendation 10

Within 6 months the trust should continue to ensure that all investigations into the alleged conduct of workers who have previously spoken up also seek to identify whether any such allegations are motivated by a desire to cause detriment because that worker spoke up and, where such evidence is found, take appropriate action. This should include amending the trust disciplinary policy to require such action.

Recommendation 16

Within 6 months a communications and engagement strategy should be developed to promote the Freedom to Speak Up Guardian and Associate Guardian's role, and to evaluate the impact it is having, in the longer term. This should include strategies to provide feedback on actions taken in response to speaking up and actions to tackle barriers to speaking up.

Recommendations to be implemented within twelve months

Recommendation 5

Within 12 months the trust should begin work to ensure that, upon the scheduled review of any trust policy and/or procedure, the policy or procedure in question is in alignment with good practice in relation to the freedom to speak up.

Recommendation 9

Within 12 months the trust should take steps to address bullying behaviour, including training for all staff relating to the awareness and handling of such behaviour.

Recommendation 13

Because of the particular needs of the trust to improve its speaking up process and culture it is recommended that, within 12 months, the trust should provide all workers with mandatory, regular and updated training on speaking up, including for those with responsibility for handling concerns. This training should be in accordance with NGO guidance and the trust should monitor that it is effective.

Recommendation 21

Within 12 months the trust should take steps to actively promote the use of mediation, where appropriate, to resolve issues arising from speaking up.

Recommendation 23

Within 12 months the trust should take all appropriate steps to identify which staffing groups in the trust feel particularly vulnerable when speaking up, why this is the case and how those groups can be supported to speak up freely and protected from any detriment for having done so.