National Guardian
Freedom to Speak Up

Derbyshire Community Health Services NHS Foundation Trust

A case review of speaking up processes, policies and culture

June 2018

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Foreword

The latest case review from my office was in response to a referral from a worker regarding the handling of their speaking up. We accepted the referral because the initial evidence indicated that considerable learning could be derived from a review to help improve the trust's speaking up culture and so it has proved.

Following the start of our review other trust workers also came forward to share their experiences of speaking up and, where they also provided learning, we have reported on their experience. In particular, our review identified improvements that needed to be made in relation to the timeliness and independence of investigations. Our review also found that the way that HR policies and procedures are applied could act as barriers to speaking up.

I am concerned that too often the combined effect of barriers to speaking up and delays in properly responding to issues raised place burdens and unacceptable levels of stress upon workers. It also can cause significant costs for trusts, as well as delaying vital learning and improvement.

The learning my office has identified in this report is not only to support the trust and to improve its speaking up culture, but for all NHS trusts to adopt these recommendations in accordance with the new guidance for boards that my office jointly published with NHS Improvement in April 2018.

I would like to thank the trust leaders, the Freedom to Speak up Guardian and workers for their generosity of time and providing all the information necessary to complete this important review. In addition, I would also like to thank the support and positive contributions from the Department of Health and Social Care and from Capsticks Human Resources Advisory Service.

Dr Henrietta Hughes, National Guardian for the NHS

Executive summary

The National Guardian’s Office (NGO) conducted a review of the handling of speaking up at Derbyshire Community Health Services Foundation Trust after receiving information that the trust might not have responded to one of its workers speaking up in accordance with good practice.

During our review, other individuals came forward to share their experiences of how the trust handled their speaking up cases, which we then also reviewed.

Our review took place from January to March 2018.

Our review sought to identify learning on how support for speaking up could be improved, as well as to highlight existing good practice.

We found that the trust’s handling of the speaking up cases we reviewed did not always meet with good practice, including long delays in the handling of workers’ issues and a poor understanding on the part of some managers of how they should respond to them. This highlighted the need for dedicated speaking up training across the organisation, to ensure that all staff have the necessary skills and knowledge to speak up well and respond to issues being raised appropriately.

We also found that speaking up policies and procedures needed significant improvement, although the trust was making necessary improvements at the time of our review.

The review also identified examples of good speaking up practice at the trust. These included a detailed communications plan to raise speaking up awareness with all workers spread across the wide geographical area covered by the trust.

There was also a dedicated speaking up web page for staff on the trust internal communications system that provided workers with information on how to speak up and included positive messages from senior leaders promoting this support, as well as a description from a worker of how this support had helped them.

Trust leaders emphasised to us that they were looking to continuously develop and improve the trust’s speaking up processes and culture, and expressed a desire to learn from our review.

Trust leaders also highlighted that one of the cases we have described in this report began before the Francis Freedom to Speak Up review had published its findings. Since that time, they believe they have moved the trust’s speaking up culture forward, on the basis of the recommendations from the Francis review, as well as from lessons learned from speaking up cases within the trust.

Our review makes 12 recommendations for the trust on how it can improve its support for its workers to speak up. In addition, we also make a recommendation for the Department of Health and Social Care and a recommendation for Capsticks Human Resources Advisory Service.

With each recommendation we have indicated the time frame within which we expect the organisation in question to implement the necessary actions.

Introduction

The National Guardian's Office

The National Guardian's Office (NGO) provides leadership, support and guidance on speaking up in the NHS. It was set up in 2016 in response to recommendations made in Sir Robert Francis' Freedom to Speak Up review.

The NGO's work is divided into two principal areas. Firstly, it provides training, guidance and support to the network of Freedom to Speak Up Guardians across secondary care in England; secondly, it reviews cases where the response of a trust to matters raised by its workers appears not to have met with good practice.

Leadership of this work, and support and challenge to the health system about speaking up, is provided by the National Guardian.

The National Guardian's Office is an independent body, sponsored by NHS Improvement, NHS England and the Care Quality Commission. It is not a regulator. Instead, it carries out all aspects of its work in collaboration with relevant bodies and individuals, including trusts and their workers.

Further information regarding the NGO is available here.

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

Case reviews

The National Guardian's Office (NGO) reviews how NHS trusts and foundation trusts have supported their workers to speak up, where it receives evidence that this support appears not to be in accordance with good practice.

The primary focus of a case review is on identifying as much learning as possible about how speaking up arrangements and cultures can be improved.

The standards of good practice against which we assess the actions of trusts are found in a range of sources, including the Francis Freedom to Speak Up review and NHS Improvement's national speaking up policy.

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 we find evidence during a case review that a trust's support for speaking up has not met with good practice, we will make recommendations about how the trust should improve this. We will also highlight examples of good practice and commend innovation.

We publish our case review reports on our web pages.

The NGO launched a 12 month pilot of its case review programme in June 2017. At the end of the pilot, we will evaluate the process to see how it can be improved.

More information about NGO case reviews is available here.

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

Learning for all NHS trusts and foundation trusts

We expect all NHS trusts and foundation trusts to look at our case review reports to identify whether they can adopt the recommendations within to help improve their speaking up culture.

We also expect trust boards to follow the guidance for boards on freedom to speak up in NHS trusts and foundation trusts, jointly produced by NHS Improvement and the National Guardian's Office, published in April 2018. A link to this guidance is available here.

Why we conducted a case review at Derbyshire Community Health Services NHS Foundation Trust

The National Guardian's Office received information that indicated the trust's handling of a case of speaking up by one of its workers might not have been in accordance with good practice. We decided to review this case because of the potential for learning that could be obtained from it, not only for this trust, but all trusts across secondary care.

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

Working with the trust to undertake our review

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

How we conducted our review

We reviewed a range of documents relating to the cases of the workers whose experiences of speaking up we looked into, as well as other documents relating to speaking up in the trust. These included trust policies and procedures, reports from the Freedom to Speak Up Guardian and staff survey results.

We visited the trust in February 2018 to carry out a series of interviews. These were with executive and non-executive members of the board, the Freedom to Speak Up Guardian, senior human resources managers, a former trust governor and a trade union representative.

We carried out further interviews with some of these individuals and others over the phone.

In each of the cases we describe below, we first obtained the consent of the workers involved to discuss their case with the trust.

Where we found issues that needed to be addressed promptly, we immediately raised them with trust leaders.

We work collaboratively with NHS Improvement and the Care Quality Commission, who have regulatory responsibility for the trust, to ensure they are fully aware of our findings and can support the trust to implement our recommendations.

Recommendations and actions

In response to the learning we identified in each of the case studies, we have set our recommendations below on how the handling of speaking up should be improved.

We have made recommendations for three separate organisations: the trust, the Department of Health and Social Care and Capsticks HR Advisory Service. We will ask each of these organisations to provide us with an action plan within 28 days of the publication of this report to detail how they intend to implement our recommendations.

We expect our recommendation for Capsticks HR Advisory Service to be followed by all individuals and bodies that NHS trusts and foundation trusts commission to investigate workers' speaking up cases.

Examples of good speaking up practice in the trust

In addition to the learning we identified, we found examples of good speaking up practice in the trust, including:

- A detailed communications plan that provided a variety of methods for raising speaking up awareness to all staff across the wide geographical area of the trust, including poster campaigns, messages and screensavers on internal staff communication systems, on staff payslips and to the mobile phones of community nurses
- Web pages on internal staff communications dedicated to speaking up, providing contact information for the trust's Freedom to Speak Up Guardian, relevant policies and procedures

and descriptions from workers on how speaking up in the trust had been a positive experience for them

The structure of this report

This report consists of 3 case studies representing the individual experiences of workers who spoke up while working at the trust.

The case studies, as far as possible, are anonymised to protect the identity of individuals concerned and to ensure that the focus of this case review is on learning and improvement.

In each case study, we first summarise the background information before setting out our findings.

Our recommendations are set out below each aspect of learning we have identified.

About the trust

Derbyshire Community Health Services NHS Foundation Trust (DCHS) was created as a standalone NHS organisation in April 2011. The trust gained foundation status in 2014, giving it greater autonomy over its governance.

With around 4,500 members of staff, DCHS caters to a population of over a million people, providing care for more than 4,000 patients a day.

The trust delivers its services through 133 sites including 13 community hospitals and 28 health centres.

The trust was last inspected by the Care Quality Commission (CQC) in May 2016.

The CQC assesses how well services support workers to speak up under its 'well-led' domain.

In its last inspection, the CQC rated the trust as 'good' in all areas (safe, effective, responsive to the needs of service users and well-led) except for caring, where it was rated as 'outstanding'.

A link to the inspection report can be found here.

Acknowledgements and thanks

In completing this review we want to thank those individuals and organisations with whom we engaged and who provided their support.

In particular, we would like to thank those workers who gave considerable time to share their speaking up experiences.

We would also like to thank the trust for its active collaboration in providing all necessary information and making staff freely available to permit the completion of our review.

Finally, we would like to thank those individuals and bodies included in the list below for their support, input and guidance.

Our thanks to:

- Trust workers who have shared their experiences of speaking up
- The leaders of the trust
- The trust's Freedom to Speak Up Guardian
- Care Quality Commission
- NHS Improvement
- NHS Employers
- NHS Providers
- Capsticks LLP
- Capsticks HR Advisory Service
- Department of Health and Social Care

Case study 1

A: Background summary

Worker A was the head of a service run by the trust. They were informed by their line manager of a proposal to review the options for delivery of the service, including its possible outsourcing to an external provider.

Worker A was not included in the initial discussions around this proposal.

They described that the proposal was based on information that they believed was inaccurate. They also told us that the potential outsourcing of the service would pose a risk to its users.

Worker A spoke up about this in a meeting with their line manager.

Shortly after this meeting, the trust suspended Worker A to investigate allegations made against them by some of their colleagues. Worker A claimed that the allegations against them, as well as their suspension, were acts of retaliation against them for speaking up.

Worker A asked that their concerns be looked into under the trust's speaking up policy as it existed at the time ('Whistleblowing Policy'). Worker A also claimed that their speaking up constituted a protected disclosure under the Public Interest Disclosure Act 1998.[1]

However, their line manager said that it was not appropriate to investigate this matter using the trust's whistleblowing procedure. They also disputed that Worker A's speaking up amounted to a protected disclosure.

Instead, the manager advised Worker A that the issue they had spoken up about would be taken forward as a grievance.

Disagreement between Worker A and the trust about whether their speaking up was a protected disclosure and whether or not it should be handled under the trust's whistleblowing procedure continued for several months after they had first raised the issue.

Approximately four months after Worker A had spoken up about proposals to review the options for delivery of their service, their line manager appointed HR staff to look into the matter raised by Worker A. However, these were the same HR staff that were already looking into the allegations raised against Worker A. Worker A challenged this appointment, saying that such individuals were not appropriately independent to look into the issue about which they had spoken up.

[1] Where an employment tribunal rules that a worker has made a protected disclosure under the Act they may award compensation if they also find that a worker suffered detriment for having made that disclosure.

Shortly after, it was agreed between Worker A and the trust that an investigation into the speaking up matter should be paused until the investigation into the allegations against Worker A was concluded. Consequently, no further action was taken to look into Worker A's speaking up issue for several weeks.

Approximately seven months after Worker A first spoke up the trust then appointed Capsticks HR Advisory Service to look into the issue about which Worker A had spoken up. However, Worker A again challenged the independence of this appointment because this organisation was a subsidiary of Capsticks LLP solicitors, which was corresponding with Worker A on behalf of the trust in respect of Worker A's disciplinary process.

In response to Worker A's challenge, the trust decided to replace Capsticks HR Advisory Service with a different investigator. It also put Worker A's disciplinary process on hold.

However, Worker A became concerned about the independence of this new investigator and the trust agreed to replace them with another external investigator.

The investigation into Worker A's speaking up then began approximately 16 months after they had first spoken up.

The investigation reported its findings five months later.

To provide support to Worker A for the stress they were experiencing throughout this time the trust provided workplace support for them. The support the trust provided was in excess of the amount it was required to provide under its policies and procedures. However, a letter from the trust's solicitors to Worker A informing them that this support was to end also appeared to imply that the stress Worker A was experiencing was their fault for failing to properly engage with the speaking up investigation.

Following the conclusion of the speaking up investigation, a disciplinary hearing into the allegations against Worker A went ahead.

The speaking up investigation reached a number of conclusions, including about the merits of Worker A's original concerns. However, because the purpose of our review is to look at how the trust handled Worker A's speaking up we will only describe those findings of the trust's investigation that are relevant to this.

In terms of how the trust handled the case, the trust's own investigation report stated that:

- *"By repeatedly stating that Worker A's concerns did not amount to a 'whistleblowing' concern the trust effectively discouraged Worker A from speaking up*
- *When the allegations were first made against Worker A it was reasonable to expect that an investigator should have been appointed to look into them who was separate and unrelated to the investigation into their speaking up issue*
- *The trust's decision to end counselling support for Worker A could be regarded as a detriment against them*

- *The language used in the solicitor's letter that communicated this decision clearly upset Worker A, although it was not possible to confirm whether this was intentional*
- *The suspension of Worker A to investigate the allegations made against them was in accordance with trust policy and was not a detrimental act in response to their speaking up"*

In terms of improving the speaking up processes at the trust, the investigation's recommendations were:

- *"The trust should consider additional training for managers to handle speaking up concerns*
- *Speaking up should be investigated irrespective of whether the matter might amount also* [sic] *constitute a protected disclosure*
- *Investigations into potentially serious concerns should have proper oversight and be properly expedited*
- *Investigations should be suitably independent"*

We asked the trust what steps they were taking in response to the findings of its investigation. In response, they told us that the trust was providing more speaking up training for its staff. We discuss this training further on page 15. In respect of protected disclosures, they said that the trust's speaking up policy was being amended to ensure that decisions relating to investigating speaking up were not determined by whether or not the issue might be such a disclosure.

With regards to the assurance of the independence of speaking up investigations, they said that this (though not the carrying out of investigations) had been transferred from the trust's HR department to the Freedom to Speak Up Guardian. Trust leaders said that they have also put together a list of internal and external investigators they can readily call on to carry out independent investigations into speaking up.

In addition, the trust told us that it had reflected on its learning as a result of this case and commissioned an independent review prior to the NGO's case review. This review was in addition to the investigation described above. The trust drew up a comprehensive action plan to respond to the findings of that review. Where the findings of the trust's review coincide with our review, we comment on this below.

We asked Worker A how the trust had first responded to their speaking up and whether anyone handling the case had thanked them for doing so. Worker A replied that they had never been thanked for speaking up.

We discuss the need for thanking workers who speak up, as part of a positive working culture, further in this report.

Our findings

We have set our findings first in relation to the overall speaking up culture in the trust, then with regard to how the trust handled Worker A's case.

1. Speaking up culture

<u>Policies and procedures</u>

At the time of our review, the trust's speaking up policy (called the Raising Concerns Policy) had been in place for over two years. It was introduced during the period covered by Worker A's case.

Trust leaders explained to us that learning from the case influenced the drafting of the policy, including changing the previous name of 'whistleblowing policy' in favour of 'raising concerns policy' to make it clear that staff may speak up about any concerns.

We welcome the trust's reflection that the term 'whistleblowing' should be replaced, but we would go further and recommend that the term 'speaking up' is used for the naming of such policies to emphasise that such actions contribute to learning and improvement, as well as highlighting areas of concern.

With input from our colleagues in NHS Improvement, we reviewed whether the trust's Raising Concerns Policy is in accordance with the national, integrated freedom to speak up policy published by NHS Improvement in April 2016.

All NHS organisations in England are expected to adopt this policy as a minimum standard to help standardise the way organisations in the NHS support staff who speak up and to make speaking up business as usual in the NHS.

This policy can be found here.

In response to our immediate feedback on this point, trust leaders explained that the policy was being updated at the time of our review and that they would incorporate our observations to ensure the new policy met the needs of all its workers.

Although the trust was, therefore, undertaking to immediately implement the changes we recommended in our feedback, we nevertheless set out our observations in detail below so that other trusts may learn from our findings.

We found many aspects of the trust's policy that are supportive of freedom to speak up, including emphasising the importance of providing feedback on actions taken in response to issues raised by workers. The policy also stresses that the trust will not tolerate retaliation against workers who speak up.

However, we also found that the policy was not in accordance with the national speaking up policy. In particular, we identified three areas of concern:

- **Legal references**

As referred to above, the trust's own speaking up investigation into Worker A's case found that the trust should investigate speaking up cases regardless of whether or not they are deemed to be protected disclosures. However, the trust's policy makes extensive reference to the Public Interest Disclosure Act 1998 (PIDA), the law that provides workers who suffer retaliation for making a 'protected disclosure' a potential claim at an employment tribunal.

Extensive references to the law in a speaking up policy may confuse workers, including managers tasked with looking into speaking up issues, into thinking that a speaking up issue must also be a protected disclosure, and thereby act as a barrier to speaking up.

For comparison, the NHS Improvement's national speaking up policy only refers to PIDA in a supplementary paragraph at the end of the policy.

- **Easily understood**

Policies need to be simply explained and easy to follow to empower workers to use them to speak up. However, the trust's policy is significantly longer than the NHS Improvement speaking up policy and employs language than is needlessly complex and legalistic.

- **Encouraging**

The trust's policy states on numerous occasions that staff who 'maliciously' speak up will face disciplinary action. The policy defines 'maliciously' speaking up as when a worker raises a matter that they know to be untrue, and states that disciplinary action may be pursued against those who speak up 'maliciously'. However, such a statement is not present in the speaking up policy published by NHS Improvement.

A speaking up policy should seek to encourage workers to speak up. However, statements like those found in this policy which threatens those who maliciously speak up with disciplinary action risks discouraging workers from speaking up. For example, a worker who perhaps has a mere suspicion that something is not right may be discouraged from speaking up by such statements in a policy, worried that if their suspicion turns out to be wrong, that they could be viewed as having 'maliciously' spoken up.

Such statements may also discourage individuals who wish to speak up about issues that still relate to important matters that require investigation, but who may have ulterior motives for speaking up.

We recommend that the trust implements its revised, draft policy and that it should include the improvements we refer to above.

The NHS staff survey for the trust in 2017 indicated that staff had good awareness of how to speak up and we therefore also recommend that the trust continues to take steps to ensure that all workers are made aware of the new policy once it comes into effect.

Recommendation 1

Within 3 months the trust should publish its new speaking up policy. The new policy should be written in a way that encourages workers to speak up and is easily understood. Unnecessary references to PIDA and malicious intention in speaking up should not be present.

Recommendation 2

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

Senior leadership and culture change

An essential element in supporting a positive speaking up culture in an NHS trust or foundation trust is the support provided by the organisation's senior leaders. This is emphasised by the joint guidance to trust boards from the National Guardian's Office and NHS Improvement referred to earlier in this report.

Included in that guidance is the expectation that a trust should have both an executive and non-executive lead responsible for speaking up and this was the case in Derbyshire Community Health Services NHS Foundation Trust.

In addition, the NHS Improvement standard speaking up policy, which we expect all trusts to follow as a minimum guide, says that workers, while being able to speak up to, among others, their line managers or Freedom to Speak Up Guardian, should also be able to contact, as an alternative route, either the executive, or non-executive lead (NED) for speaking up.

We looked at how workers could access the NED for support to speak up in the trust because concerns were expressed to us that it was sometimes difficult to do so.

We found that workers were able to contact the NED via the trust secretary, who was also the Freedom to Speak Up Guardian. The trust explained that this route was necessary because the NED, as is customary in the NHS, was not provided with a secure email address.

While we commend the trust for following national guidance by ensuring the NED was contactable to support workers to speak up, we also think that the speaking up process is not fully supported if a communication channel for the NED is supervised by one of the individuals responsible for helping workers in that process.

This is because it is conceivable that there will be circumstances where a worker elects to contact the NED for support to speak up because they do not wish to use one of the alternative sources of support, such as the Guardian, or otherwise want that alternative source to know that they are seeking the NED's help.

We, therefore, make the recommendation for all trusts that lines of communication for workers to contact their NED do not place such potential obstacles in the way of speaking up.

Recommendation 3

Within 3 months the trust should ensure that workers who wish to raise matters with the trust non-executive director responsible for speaking up are able to do so via routes of communication that appropriately support their confidentiality.

A culture of valuing workers

Good speaking up practice includes valuing the views of workers and ensuring that appropriate steps are taken to support them to contribute to their work and to be free to share their opinions about the services in which they work.

This important principle was acknowledged in the standard practices of the trust, where heads of services were involved in discussions relating to any proposed changes to those services.

But, as described above, the trust chose not to involve Worker A in its initial review of options for the delivery of the service of which they were the head. When we asked a trust leader why this choice was made, they explained that this was done because Worker A was seen as a challenging individual by certain colleagues.

However, this explanation seemed to imply that the choice was taken not to consult worker A about the changes to the service they led simply because there was a perception that such conversations may have been difficult. No rationale was offered explaining how this decision valued workers.

The trust leader acknowledged that not involving Worker A in the discussions was against standard trust practice and doing so may also have created additional anxiety among the service's workers about the plans themselves.

The leader said that the trust was keen to learn from Worker A's case and that in the future the trust would ensure that it followed its standard practices relating to consulting service heads about the plans for their services.

Recommendation 4

Within 3 months the trust should ensure that, in line with its practices, it continues to value the views of its workers, including consulting staff about changes to their services where appropriate.

2. Handling concerns

Investigations

Good speaking up practice requires investigations into issues raised by workers to be conducted without undue delay. This allows for lessons to be promptly learned and serious matters such as patient safety issues to be addressed quickly.

This aspect of good speaking up practice is emphasised by the NHS Improvement speaking up policy, which directs that investigations should be conducted 'within reasonable timescales'.

As described above the investigation into the matters raised by Worker A was only concluded 19 months after they first spoke up. In the circumstances, this was not a reasonable timescale. The trust's own investigation report shared this view.

The reasons as to why the handling of this case took such a length of time are complex and varied. The trust highlighted to us their belief that delays were caused by the sickness of Worker A and in response they made every effort to be flexible and amenable to their health needs.

From the perspective of Worker A, they regarded the delays to have been principally caused by the trust's inability to appoint, in their opinion, a suitably independent person to investigate their speaking up case. They also felt that the trust's initial contention that the matter was not a 'whistleblowing' case and therefore not one appropriate for investigation under the trust's Whistleblowing Policy, as it existed at the time, also significantly delayed matters.

Our findings for the principal causes of the delay are set out below.

Firstly, delay was caused because the trust did not regard the matter as one they should investigate under its 'Whistleblowing Policy', as existed at the time. Instead, they responded to Worker A's speaking up issue by telling them that the matter would be dealt with as a grievance. In return, Worker A stated they wished the trust to investigate the matter both as a 'whistleblowing' issue and a grievance.

In its review of Worker A's case the trust also identified that too much time was spent debating whether the case met the criteria for its Whistleblowing Policy and whether or not it was a grievance.

The trust also entered into a protracted disagreement with Worker A over whether what they had spoken up about was a protected disclosure.[2]

As described above, in reference to good speaking up policies and practice, whether a matter might be a protected disclosure should not determine the response to a speaking up issue. The trust has acknowledged that it should revise its speaking up policy in line with the NHS Improvement (NHSI) speaking up policy and, at the time of writing of this report, was in the process of doing so.

[2] For clarity, it should be added at this point that the only individual who can determine whether an issue is a protected disclosure or not is an employment tribunal judge.

Secondly, delay was caused because, once the trust agreed to investigate the matter, it appointed investigators that were not regarded as independent by Worker A and who the trust then changed when Worker A challenged those appointments. The NHSI speaking up policy requires that investigators into speaking up matters should be 'suitably independent' and the trust's investigation report endorsed this principle.

When we raised the issue of the selection of investigators with trust leaders, they explained that they had acted in good faith, with the intention of appointing properly independent investigators. However, one leader acknowledged that 'perception is reality' and that there was no point in pursuing an investigation in which a worker had no confidence.

Also, the leader acknowledged that the trust understood why Worker A had perceived the trust's appointment of Capsticks HR Advisory Service as insufficiently independent, given that it was a subsidiary of Capsticks LLP solicitors, which the trust had instructed to communicate with Worker A on its behalf regarding the disciplinary matter. As a consequence, the trust leader said that in the future they would not make the same decision again.

This perception by Worker A was also described as 'understandable' by the trust's review of Worker A's case. In response to the review, and as described above, the trust has drawn up a list of independent investigators that it can commission to look into speaking up matters.

We have made a recommendation relating to Capsticks HR Advisory Service at the end of our report, which we expect to be followed by all individuals and bodies that trusts commission to investigate a worker's speaking up case.

For clarity, we would emphasise that we anticipate trusts taking a common sense approach to ensuring speaking up investigations are suitably independent which, in many circumstances, will mean undertaking an internal review by a person or persons who are suitably qualified and experienced, but who are sufficiently removed from the issues and people involved to be properly impartial.

We do not wish to imply that 'suitable independence' means commissioning external investigators in every instance.

When we discussed this case with trust leaders, they acknowledged that the trust could have handled it better and had learned lessons from both its investigation into the case, as well as its subsequent review of the case. We welcome the trust's insight into the need to improve its speaking up investigations, and the recommendations below are intended to support the steps it has begun to take.

In response to our findings, the trust have also observed that they were following the previous Whistleblowing Policy in Worker A's case, which they subsequently updated to be more in line with good practice.

We have also noted in our review that while there is a clear indication in the NHS Improvement speaking up policy that investigations should be 'within a reasonable timescale' as well as being 'suitably independent', there is no guidance from any arm's length body supporting the work of NHS trusts and foundation trusts about how these specific outcomes are to be achieved.

Given the importance for trusts and workers alike that investigations are carried out in accordance with the good practice set out in the national speaking up policy, we have made a recommendation at the end of this report for the Department of Health and Social Care in this regards.

Recommendation 5

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 6

Within 3 months the trust should take appropriate steps to ensure that all cases of speaking up are investigated by suitably independent persons.

Recommendation 7

Within 3 months the trust should take all appropriate steps to ensure that responses to cases of workers speaking up, including decisions relating to the investigation of those cases, are not focused on whether or not the matters in those cases are qualifying disclosures under the Public Interest Disclosure Act.

3. Supporting good practice

Speaking up training

It is essential that workers know how to speak up and that those responsible for handling speaking up issues have the skills and knowledge to do so as well.

We, therefore, asked trust leaders whether speaking up training is offered to workers.

In response, they told us that they are in the process of introducing dedicated speaking up training for all new and current members of staff. This short (5 mins) e-learning based training will be mandatory for all trust workers and will have to be repeated every two years.

Trust leaders also mentioned that the trust was looking into commissioning Human Factors training. According to the Health and Safety Executive, "Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety". The trust leader explained that speaking up will be embedded in this training.

The trust also highlighted the training already given to staff that related in some way to speaking up, including in respect of handling complaints, risk management and incident reporting.

While we acknowledge that such training does relate to speaking up and we welcome the fact that the trust wishes to improve its speaking up culture, we do not believe, on the basis of the evidence from our review, that that five minutes dedicated speaking up training every two years will be sufficient to ensure that all staff have the necessary skills and knowledge to speak up well and respond to issues being raised appropriately.

Moreover, speaking up awareness training should be embedded across the fabric of the organisation, from training and induction, staff development at all levels, to team meetings and staff recognition, utilising appropriate communication channels available to the trust.

Recommendation 8

Within 12 months the trust should develop a plan for embedding speaking up in the organisation. This plan should consider the use of staff inductions, team meetings, leadership training and other mechanisms to ensure that all staff have the necessary skills and knowledge to speak up well and respond to issues being raised appropriately.

As part of this plan, a communication strategy should be developed to promote the trust's Freedom to Speak Up Guardian and encourage workers to speak up to them when they feel they cannot speak up using other channels.

Case study 2

A: Background Summary

Worker B was concerned about the conduct of colleagues in their team. Worker B described that the conduct of their colleagues significantly affected the morale of other team members and, because of the positions of the colleagues accused of poor conduct, also made team members afraid of speaking up about their behaviours.

Worker B said that they had wanted to speak up about this conduct to local management, but were initially reluctant to do so because they did not trust many managers as they believed that inappropriately close relationships existed between many of them.

Worker B said they believed that another member of staff had spoken up previously, only to suffer retaliation. They expressed the view that this outcome served to further erode workers' confidence to speak up.

Worker B said that they eventually decided to share their concerns with the trust's Freedom to Speak Up Guardian.

However, they explained that they were disappointed with the speaking up arrangements in place in relation to Guardian support. Firstly, they described that they felt that their confidentiality was not properly protected when obtaining this support. This was because, having agreed to meet the Guardian during working hours, Worker B was first taken across their workplace to a meeting room, in full view of their colleagues, something that they were not expecting would happen.

Secondly, they said that they did not receive adequate feedback during the speaking up process. Thirdly, they described that there was not a proper acknowledgement of how difficult it was for them to have spoken up in the first place.

We raised the issue of the trust's speaking up arrangements in this case with the trust Freedom to Speak Up Guardian. In response, they told us that proper account had been taken of the need to protect Worker B's confidentiality. The trust said that Worker B agreed to meet at the venue described on two occasions and the Guardian emphasised that workers were free to meet them at any time or location that suited the staff member concerned.

However, the Guardian did not acknowledge that Worker B's confidentiality risked being undermined by them walking through the workplace in front of colleagues in the company of those tasked with hearing their speaking up.

In terms of providing feedback, the Guardian explained that this was given to Worker B in their case, but that certain details were not given regarding actions taken to protect the confidentiality of the trust workers whose alleged improper conduct was the issue of the speaking up.

The Guardian gave no information regarding whether those involved in responding to Worker B's case either understood or empathised with Worker B about how difficult speaking up had been for them.

Our findings

1. Handling concerns

Investigations

Given the trust's feedback in this matter, we observe that equal consideration should be given to preserving the confidentiality of those workers who speak up, as is afforded to those about whom they raise issues.

An essential element in promoting freedom to speak up is the protection of an individual's confidentiality in all cases where requested, except where exceptional circumstances apply. Therefore, appropriate steps must be taken to ensure that an individual feels safe when meeting to discuss their case.

In looking at the speaking up arrangements in the trust, in this and other cases, we also found that not all matters raised by workers with the trust's Freedom to Speak Up Guardian were recorded. Instead, the trust only recorded those instances of speaking up where the worker described that they were doing so 'formally'. This is not in accordance with training and guidance provided by the National Guardian's Office.

On this point, the trust commented that it would not be appropriate or possible for the Guardian to record every conversation that they had with workers. They also stated that senior trust leaders pride themselves on their visibility and accessibility, but that acting upon all informal discussions between them and trust workers was not practical.

We accept the point the trust is making in this regard, including the number of informal conversations the trust Freedom to Speak Up Guardian has, as they are also the trust's company secretary. However, given the trust has appointed its company secretary to also perform the role of Freedom to Speak Up Guardian it must decide how best to ensure that their accessibility as a trust leader does not compromise their ability to record all matters raised with them in their Guardian role.

Failure to record all matters raised with the Guardian, whether workers raise them 'formally' or otherwise, creates the dual risk that workers may not receive the support they require to speak up and that trusts may not be fully aware of all issues raised by their workers.

As with the other case studies in this report, we asked Worker B if anyone in the trust had thanked them at any time for speaking up. They replied that they did not recall receiving any such thanks.

For balance, a trust leader told us that there is a culture of thanking staff for speaking up and highlighting issues where the trust needs to do better and that speaking up training for staff

emphasises the importance of doing this. We, therefore, conclude that each of the case studies, in this respect, are examples of where that culture and training were not being followed.

We make further reference to this, with an associated recommendation, below in case study 3.

Recommendation 9

Within 3 months the trust should ensure that their speaking up arrangements, including the support provided by the Freedom to Speak Up Guardian, appropriately protect workers' confidentiality, and demonstrates appropriate understanding and empathy for the needs of individuals.

Recommendation 10

Within 3 months the trust should ensure that the Freedom to Speak Up Guardian records all instances of speaking up raised to them, not just those cases where workers state that they are raising a matter 'formally'.

Case study 3

A: Background Summary

Worker C told us they became concerned when they heard members of staff making inappropriate comments about co-workers.

Worker C reported the incident to trust management, stating they were raising it as a grievance. Worker C explained to us that they described it as such because they were angry about what they had witnessed and regarded it as serious. Worker C also explained that they were not aware of routes, other than grievances, through which they could speak up about the inappropriate comments they had allegedly witnessed. In response to Worker C reporting the incident, the matter was passed to the relevant team leader.

Worker C told us that they then did not receive any feedback regarding the progress of their case for several weeks, in spite of chasing it up on several occasions.

Worker C said that during this period no one from the trust discussed the case with them, including how the trust intended to handle the matter, whether Worker C required any support, or the possible alternative processes available for responding to their speaking up.

Worker C described to us that this absence of communication and support left them feeling 'isolated'. They added this isolation made worse the distress and anxiety they already felt from having witnessed the alleged inappropriate remarks.

Worker C then told us that, after five weeks had passed, they believe they were informed by the trust HR department that the absence of feedback up to that point was because their grievance had gone into the inbox of an HR staff member who had been off sick and the grievance had not then been picked up by any of their colleagues.

The trust acknowledged that this delay took place, but instead told us that it was because the manager responsible for handling the case had mistakenly thought that the matter had been escalated and was being dealt with by a colleague.

At this stage, a meeting was then arranged between Worker C and HR staff to discuss their grievance in a further two weeks' time.

Worker C explained to us that, at this meeting, the human resources manager was sympathetic to the stress that this case had caused them and suggested that they utilise the trust's counselling services. Worker C accepted this offer and told us they found it a valuable source of support throughout the speaking up process.

However, Worker C added that they did not recall being thanked at any time by anyone from the trust for having spoken up.

Following this meeting the trust began an investigation into Worker C's grievance. However, Worker C said that they were not kept updated about the progress of the investigation.

Although a Freedom to Speak Up Guardian was in place at the time of this case Worker C said they were not aware of their existence.

Our findings

1. Handling concerns

We discussed this case with a senior trust leader.

The senior leader acknowledged that there was a delay in the handling of this case. However, they said that the reason for it was because the worker's manager had mistakenly believed that the grievance had been escalated to human resources when it had not. They explained that the trust would, therefore, be looking at what steps could be taken to prevent such a failure of communication in the future, though they did not specify what those steps might be.

We asked them about the fact that Worker C had raised this matter as a grievance and whether the grievance process was the most suitable to support the needs of the Worker. We asked this because grievance processes are specifically designed to support workers to raise issues relating to their employment and working conditions and trigger specific processes that may not always be supportive to workers who wish to speak up about certain issues.

In the case of Worker C, they alleged they had witnessed inappropriate comments by their colleagues regarding other workers. While such alleged conduct did affect Worker C's working conditions, and so could be potentially raised by them as a grievance, under the trust's grievance policy this then triggered a specific series of procedures, including a three stage process, the first of which was informal resolution involving discussion between the parties involved.

However, Worker C made it clear to the trust that they did not want to discuss the incident with the individuals they alleged to have witnessed, as they felt this would have been very stressful for them.

Therefore, although the grievance process in this case was technically applicable to the concern Worker C was raising, in practice it did not meet their needs.

As described, after Worker C had spoken up, no one from the trust met with them to discuss options as to how the matter could be handled, for example under the trust's Raising Concerns Policy. If the trust had supported Worker C using this process, instead of the grievance procedure, they would not have been asked to consider attending informal meetings with the persons they had spoken up about that would have been very difficult for them.

The absence of any meeting to discuss available options for handling their case was despite the fact that the trust's grievance policy required a 'scoping meeting' to take place between the worker and their line manager within 28 days of the grievance being brought to discuss how the grievance would proceed. As described, Worker C only met HR staff to discuss their case several weeks after speaking up.

The trust's policy describes that the meeting's purpose is to 'discuss the nature of the complaint' [in order to make] a decision on how to proceed'. We believe that such meetings should be used to not only discuss the grievance itself but the policies and processes available to respond to a worker's speaking up issues that best meet their needs.

In responding to our questions about Worker C's case the trust senior leader said that they believed it was appropriate for the matter to be handled as a grievance. They said this was because the trust has a flexible approach to deciding which policies they use to process such matters. If a worker wants a matter to be handled as a grievance or a speaking up issue, the trust would not dictate to them that it should be otherwise.

However, while we understand this flexible approach, the trust's speaking up arrangements did not support Worker C to make an informed choice on the matter. This was because no one met with Worker C to discuss their case within 28 days of them speaking up, as required by the trust policy and the policy did not state that this meeting should be used to discuss the range of alternative methods and processes for handling the matter.

It is important that trusts and workers discuss these options because of the potential burdens that grievance processes can place upon workers. Where the trust's grievance procedures are used to respond to workers' speaking up issues, they must be followed, but as we describe below, they should also be amended to provide better support for workers.

The trust grievance policy also made no mention of any ongoing speaking up support available to workers bringing a grievance. Such support should include information on available support to workers dealing with stress as well as from the trust's Freedom to Speak Up Guardian, should the worker want to raise new matters.

This omission should be addressed because processes which place burdens on people who speak up, take too long, or during which feedback is not provided, are barriers to speaking up.

This may prevent others from speaking up while also discouraging the individual from speaking up about matters beyond the immediate scope of that grievance, including potentially serious patient safety or staff welfare issues.

Our recommendations in relation to grievances, therefore, incorporate the need for policies to appropriately provide for such support.

We also recognise that trusts require appropriate guidance when supporting their workers to speak up, particularly, as this report highlights, in the field of human resources (HR) and how HR professionals respond to speaking up cases. We, therefore, make recommendations at the end of this report for additional support to be provided to trusts in this regard.

We make a further recommendation for the trust in respect of ensuring that they meaningfully thank all workers who have spoken up, regardless of the issues raised. As described in the first case study the worker was certain they were not thanked; in case studies two and three the workers did not recall this happening. Thanking all workers who speak up is an essential element in promoting a positive speaking up culture in any working environment.

Recommendation 11

Within 3 months the trust should take appropriate steps to ensure that where the grievance process is used to respond to a worker speaking up the trust's grievance policies and procedures are correctly followed, including in respect of providing an initial scoping meeting to discuss the matter the worker is speaking up about and the range of alternative processes for handling it.

Recommendation 12

Within 12 months the trust should take appropriate steps to ensure that all workers who speak up are meaningfully thanked for doing so, in accordance with trust culture, training and good practice.

Other recommendations resulting from this review

On the basis of information we obtained during our case review we are also making recommendations for other bodies, in addition to the trust, on steps they should take to improve support for NHS workers who speak up.

For Capsticks HR Advisory Service and all individuals and bodies responsible for investigating cases of speaking up in secondary care

As described in case study 1 the trust appointed Capsticks HR Advisory Service (HRA) to investigate Worker A's speaking up issue. At the same time, the trust was instructing Capsticks LLP solicitors, the parent company of the advisory service, in relation to Worker A's disciplinary proceedings.

Worker A objected to the trust's appointment of the advisory service on the basis that it was not suitably independent to look into their speaking up case, in response to which the trust replaced the advisory service with another investigator. A trust leader told us during the review that they would not employ two such related organisations in the same way in the future because it could lead workers to believe that investigations into their speaking up were not suitably independent.

Because Capsticks LLP and Capsticks HRA provide services to many trusts across England we also discussed with a senior leader at Capsticks about how they assured themselves of the independence of their service's speaking up investigations where Capsticks LLP are also acting on behalf of the same trust in a disciplinary matter with the worker who spoke up.

The senior leader explained that Capsticks Solicitors LLP and Capsticks HRA are different organisations, with different staff, that operate independently of each other.

In addition, they said Capsticks is bound by robust regulatory rules on managing conflicts of interest, as laid out by the Solicitors Regulation Authority. Their HR investigators are also appropriately qualified and have a professional duty to act with absolute integrity.

The senior leader said that they communicated to Worker A the independence of investigations by Capsticks HRA.

However, this reassurance was provided after Capsticks HRA were appointed as investigators in Worker A's case. The senior leader said that they did not previously provide assurances to workers regarding the independence of their investigations as a matter of course. These assurances were only communicated if and when it was raised as a potential issue.

As discussed earlier in this report, investigations into speaking up issues, in accordance with the NHS Improvement speaking up policy, should be independent and therefore should be seen to be so, especially by the workers who have spoken up. Where investigations are not perceived as independent this can undermine confidence in the speaking up process.

Therefore, to support confidence in the speaking up process, we recommend that Capsticks HRA, as well as all individuals and bodies commissioned by trusts to investigate their workers' speaking up cases, communicate to the workers concerned the steps they take to assure themselves of the

independence of those investigations. This should always be done prior to the commencement of an investigation.

Recommendation 13

Within 3 months Capsticks HR Advisory Service should take all appropriate steps to ensure that it communicates to workers at their first contact whose speaking up concerns it is investigating of the actions it takes to ensure the independence of its investigations. This assurance should be provided to the workers concerned prior to the commencement of the investigation.

For the Department of Health and Social Care (DHSC)

As described in case study 1, the NHS Improvement speaking up policy requires investigations into speaking up matters to be within reasonable timescales and to be suitably independent.

In order not to present a barrier to speaking up, people who speak up about matters that require investigation should be supported and feedback should be given to them as the matter progresses as well as at the end of the process. However, there is a lack of guidance for trusts on how to ensure this happens.

Guidance on handling speaking up cases for NHS trusts and foundation trusts provided by NHS Employers do not currently cover the handling of investigations. This guidance can be found here.

As described in case study 3, we believe that both workers and trusts will benefit from appropriate guidance relating to speaking up and when a grievance process may be the most appropriate and supportive response. Again, the above guidance from NHS Employers, does not provide information on how to remove barriers to speaking up in relation to grievance processes.

We, therefore, make the following recommendation to DHSC to commission relevant guidance from NHS Employers:

Recommendation 14

Within 12 months, the Department for Health and Social Care should commission NHS Employers to develop and communicate guidance to NHS trusts and foundation trusts that will help ensure HR policies and processes do not present real or perceived barriers to speaking up. This should focus on how trusts can ensure that investigations into speaking up matters are undertaken by suitably independent persons and are completed within reasonable timescales, to enable workers who speak up to have trust and confidence in the process.

Guidance should also be provided on how to support individuals who are speaking up about a grievance to prevent undue burdens being placed on those individuals and to ensure that they receive the support they need at what is likely to be a difficult and stressful time.

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.

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 – 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 work is completed by the body in question to implement each recommendation.

Recommendations to be implemented within three months

Recommendation 1

Within 3 months the trust should publish its new speaking up policy. The new policy should be written in a way that encourages workers to speak up and is easily understood. Unnecessary references to PIDA and malicious intention in speaking up should not be present.

Recommendation 3

Within 3 months the trust should ensure that workers who wish to raise matters with the trust non-executive director responsible for speaking up are able to do so via routes of communication that appropriately support their confidentiality.

Recommendation 4

Within 3 months the trust should ensure that, in line with its practices, it continues to value the views of its workers, including consulting staff about changes to their services where appropriate.

Recommendation 5

Within 3 months the trust should take all appropriate steps to ensure that all cases of speaking up are investigated within reasonable timescales and without undue delay.

Recommendation 6

Within 3 months the trust should take appropriate steps to ensure that all cases of speaking up are investigated by suitably independent persons.

Recommendation 7

Within 3 months the trust should take all appropriate steps to ensure that responses to cases of workers speaking up, including decisions relating to the investigation of those cases, are not focused on whether or not the matters in those cases are qualifying disclosures under the Public Interest Disclosure Act.

Recommendation 9

Within 3 months the trust should ensure that their speaking up arrangements, including the support provided by the Freedom to Speak Up Guardian, appropriately protect workers' confidentiality, and demonstrates appropriate understanding and empathy for the needs of individuals.

Recommendation 10

Within 3 months the trust should ensure that the Freedom to Speak Up Guardian records all instances of speaking up raised to them, not just those cases where workers state that they are raising a matter 'formally'.

Recommendation 11

Within 3 months the trust should take appropriate steps to ensure that where the grievance process is used to respond to a worker speaking up the trust's grievance policies and procedures are correctly followed, including in respect of providing an initial scoping meeting to discuss the matter the worker is speaking up about and the range of alternative processes for handling it.

Recommendation 13

Within 3 months Capsticks HR Advisory Service should take all appropriate steps to ensure that it communicates to workers at their first contact whose speaking up concerns it is investigating of the actions it takes to ensure the independence of its investigations. This assurance should be provided to the workers concerned prior to the commencement of the investigation.

Recommendations to be implemented within six months

Recommendation 2

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

Recommendations to be implemented within twelve months

Recommendation 8

Within 12 months the trust should develop a plan for embedding speaking up in the organisation. This plan should consider the use of staff inductions, team meetings, leadership training and other mechanisms to ensure that all staff have the necessary skills and knowledge to speak up well and respond to issues being raised appropriately.

As part of this plan, a communication strategy should be developed to promote the trust's Freedom to Speak Up Guardian and encourage workers to speak up to them when they feel they cannot speak up using other channels.

Recommendation 12

Within 12 months the trust should take appropriate steps to ensure that all workers who speak up are meaningfully thanked for doing so, in accordance with trust culture, training and good practice.

Recommendation 14

Within 12 months, The Department for Health and Social Care should commission NHS Employers to develop and communicate guidance to NHS trusts and foundation trusts that will help ensure HR policies and processes do not present real or perceived barriers to speaking up. This should focus on how trusts can ensure that investigations into speaking up matters are undertaken by suitably independent persons and are completed within reasonable timescales, to enable workers who speak up to have trust and confidence in the process.

Guidance should also be provided on how to support individuals who are speaking up about a grievance to prevent undue burdens being placed on those individuals and to ensure that they receive the support they need at what is likely to be a difficult and stressful time.